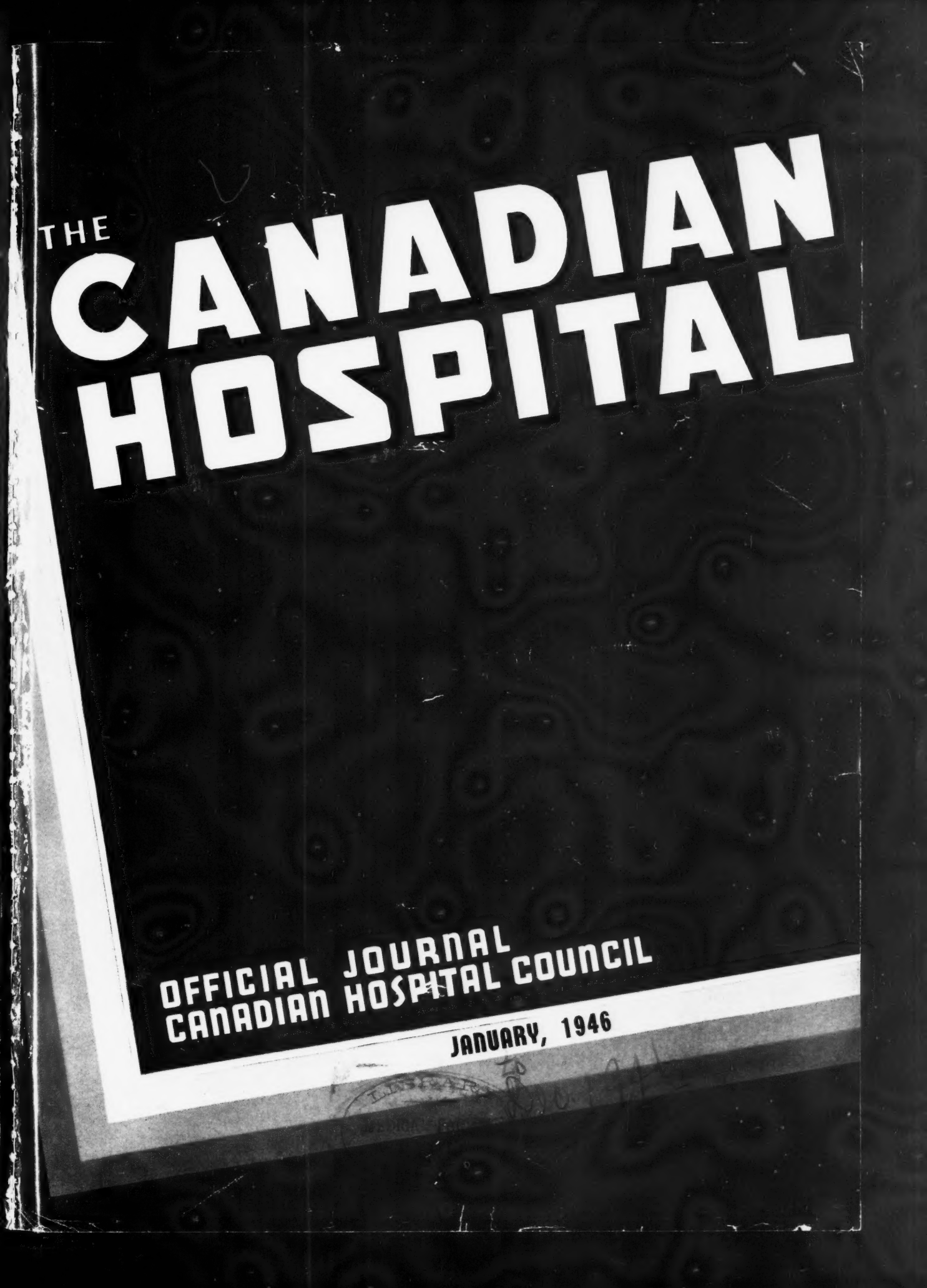
THE CANADIAN HOSPITAL



OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

JANUARY, 1946

A BETTER LAUNDRY DEPARTMENT Means

Lower Operating Costs

KITCHEN

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DINING ROOM

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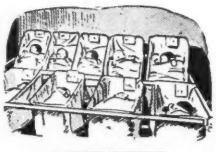
NURSERY



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OPERATING ROOM

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Since clean linen is necessary to the proper performance of every hospital department, **cutting your laundry costs has far-reaching effect.** Write today – setting a date for our Laundry Advisor to acquaint you with the latest developments in laundry machinery and methods. He can suggest, from his fund of knowledge and experience, how you can cut **your** laundry costs!

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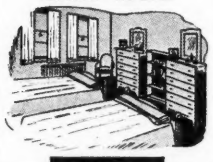

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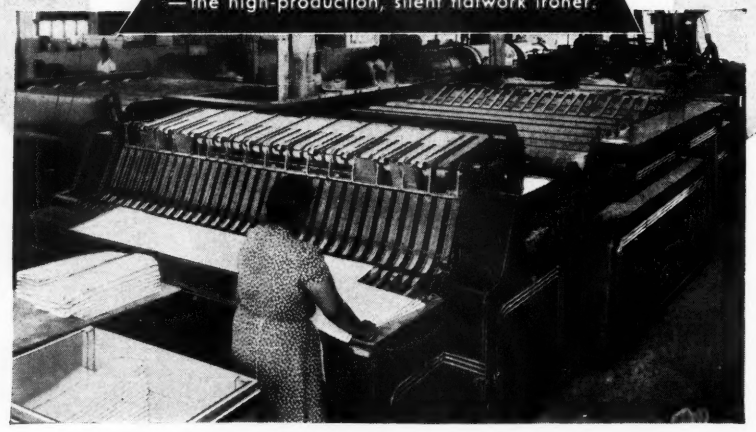

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Contents

Vol. 23 **JANUARY, 1946** No. 1

EDITORIAL OFFICES: 280 BLOOR ST. WEST, TORONTO 5, ONT.

CCAB

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ANTISEPSIS

In Rare Conditions and Everyday Practice

'The successful use of intrapleural lavage in a 'case of pyothorax and bronchial fistula was des- 'cribed by Gilmour in 1937. The chosen antiseptic 'was Dettol which was used first in a concentration 'of 1 in 20 and later at full strength. At the end 'of each washout 20 c.c. of pure Dettol was left in 'the pleural cavity. Some of this was coughed up 'via the fistula, and some swallowed with no ill 'effect. The treatment was continued for 7 weeks, 'at the end of which the pleural space was obliter- 'ating, the fluid serous, and the patient's general 'condition very satisfactory. Recovery was 'uneventful.' *

* Santon Gilmour. (1937) *Tubercle, vol. 19, p.105.*

A rare case—admittedly: yet not without some bearing on problems in everyday practice.

For what can reasonably be concluded about the attributes of an antiseptic that could be so used, for so long, and with such a result? Obviously it must have been highly bactericidal; it must have been non-toxic, even at full strength and even on prolonged contact with the pleura and the gastro-intestinal mucous membrane; it must also have been non-irritant and non-corrosive, for otherwise it would have increased the vulnerability of the tissues to the infection and inhibited the natural processes of healing.

And in fact the clinical experience of over 12 years, in all the contingencies of practice that call for rapid, effective and safe antisepsis, has shown that "Dettol" does combine, in high measure, these fundamental attributes of an antiseptic for general use in medicine, surgery and obstetrics.

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Across the Desk

By C. A. E.

How the Editorial "We" Started

HERE is the derivation of the word "editor" and the origin of the editorial "we". It comes from George James, of the Bowmanville Statesman, who clipped it from another paper which reprinted it from a contemporary which lifted it from somewhere else, its original origin being lost in the misty past. "The word 'editor'," says the clipping, "comes from the Latin 'edi', meaning to give or put out, and 'taurus'—Spanish 'toro'—meaning the bull. As to the editorial 'we'—in the prehistoric days, when editors carved their papers on stone, an editor bawled out a citizen for not paying his taxes. The fellow came with a big, knotty war club, hammered on the lintel of the cave, peered into the darkness and howled, 'Come out of there, you lily-livered so-and-so!' The editor, doing some peering in return and seeing who it was, yelled back, 'All right, you ditto, we'll be there in a minute!' The irate subscriber, not being prepared to make war on a gang, hurriedly fled, and soon forgot the incident."—Ad-Sales Events.

* * * *

Pullman Co. May Sell Out to Railroads

In March last the Federal Court in Philadelphia ordered the sale by Pullman, Inc. of the Pullman Company. The sale of the company to the railroads is now contingent only upon the approval of the Court.

The Pullman Company's function is to furnish the sleeping cars and adequately to man and maintain them under contracts with the individual railroads. The railroads, not Pullman, make the time schedules and haul the cars, determine the number and character of the sleeping cars on trains, the speed of trains and all such other elements. Pullman, under a contract, is on the railroads only because it performs a service which the railroads have found helpful. It would appear that an amalgamation of the services might be in the interests of the travelling public.

* * * *

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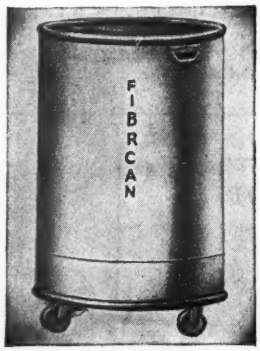
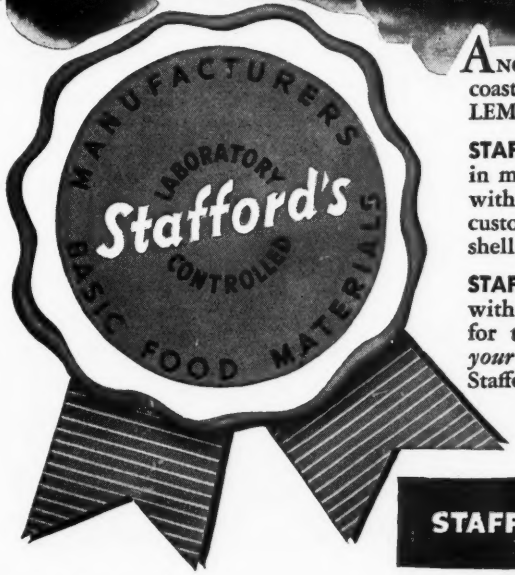
This "Four-Wheel Skater" is a product of Fibrcan Corporation, Whitestone, N.Y. It is made of case hardened fibre and steel reinforcements. Wheels are rubber and glide easily. Especially designed for maintenance and as material handling equipment. Available in 16", 18" and 20" diameters — 30" and 36" heights. Weight capacity: 400 pounds. Literature will be sent on request.



(Continued on page 16)

The Principle Ingredients



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STAFFORD'S LEMON PIE FILLER—Especially processed for convenience in making lemon pies, desserts, tart fills, etc. Produce a lemon pie with as delicious and home-made lemony smack to it as ever won a customer—and so quick and easy to use. Cost of filling a 9-inch pie shell (scaled at 2 lbs. filling per pie) is 14¢.

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Across The Desk

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No longer a "pipe dream," homes heated without furnaces are a reality for 3,200 householders in Winnipeg. This city is unique in that it has the only system on the continent exclusively concerned with supplying automatic heat to a residential area. The system is privately owned and operated by the Winnipeg Heating Company. A separate system, the Hydro Central Steam Heating System, provides heat for approximately 264 customers in the commercial area.

Both of these central heating systems have been operating successfully for more than 16 years, despite the handicap of extreme cold in winter when 30-below temperatures are not uncommon.

So successful is central heating in the residential area that there are now 600 homes without furnaces—400 without even chimneys. All customers of the Winnipeg Heating Company get ready-made heat in the forms of either steam or water piped into their home radiation system from mains under the street.

* * * *

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A new split-second starter for fluorescent lamps—aptly called the "Jack Rabbit"—has been announced by Canadian General Electric Co. Limited.

Employing a new principle in fluorescent lamp starting, the development constitutes a major advance in fluorescent lighting practice. The split - second starting action of the device is accomplished with higher operating efficiency than is obtained with any other instant - starting systems.

The new starter, which is used with G-E 40-watt instant-starting lamps, is the product of some five years of G.E. Research.

* * * *

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This valuable annual publication, issued by the Department of Trade and Commerce, is now obtainable.

Containing almost 1,000 pages of special articles and statistical information on various phases of Canada's economy and war-time and post-war commerce, the Year Book is deserving of the interest and support of every thinking Canadian. The chapters on Social Welfare and Reconstruction, where developments such as Family Allowances, Health Insurance, and Post-War Planning for Full Employment are still in the organization stage, are of especial interest to hospital personnel.

The price is $2.00. Orders should be sent to the King's Printer, Ottawa.

(Concluded on page 20)

A SINGLE APPLICATION IS *Effective for Hours*

THE need for a dependable antipruritic frequently arises in patients hospitalized for other reasons. Especially during a prolonged hospital stay is pruritus ani apt to recur. Exacerbation of chronic pruritic skin affections, or dermatitis due to "sheet burn," is not at all uncommon. Whenever itching must be controlled, regardless of cause, Calmitol enjoys a special field of usefulness. Its specific antipruritic action is dependable and prompt. A single application directly onto the involved area is effective for hours, permitting of rest and quiet for the patient during daytime hours and uninterrupted sleep at night.

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Across The Desk

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For some years a Roman Catholic and an Anglican cathedral have been in course of erection in Liverpool. The Anglican cathedral has a floor space of 101,000 square feet, or twice that of St. Paul's, London, and the interior area of the Roman Catholic edifice is more than 120,000 square feet. In the near future the four largest churches in the world will be at Rome, Seville and two in Liverpool.

An interesting point about the two big Liverpool churches is that the architect employed by the Anglicans, Sir Gilbert Scott, is a Roman Catholic, while the Catholics engaged Sir Edward Lutyens, a Protestant.

* * * *

New "Ampule Amputator"

The Ampultator is a precision engineered diamond point scoring device which facilitates opening ampules . . . simply place the ampule in position, press, and with one complete turn of the ampule it is evenly scored to give a fast, clean break.

Its use ensures minimum ampule breakage. Strong, yet lightweight construction, will give many years of efficient service. Small, may be carried in vest pocket.

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* * * *

Dominion Oxygen Co. Announces New Warehouse

A new oxygen and acetylene warehouse located at 11013-105th Avenue, Edmonton, Alberta, has just been announced by Dominion Oxygen Company, Limited, a Unit of Union Carbide and Carbon Corporation. This new warehouse will provide a convenient point for supplying two of the Company's principal products, "Dominion" oxygen and "Prest-O-Lite" acetylene.

* * * *

Persistency

Salesman: "I've been trying to see you all week. When may I have an appointment?"

Purchasing Agent: "Make a date with my secretary?"

Salesman: "I did, sir, and we had a grand time, but I still want to see you."

* * * *

Sgt.: "How is it you don't like the girls?"

Pvt.: "They're too biased."

Sgt.: "Biased, what do you mean?"

Pvt.: "It's bias this and bias that, until I'm broke."

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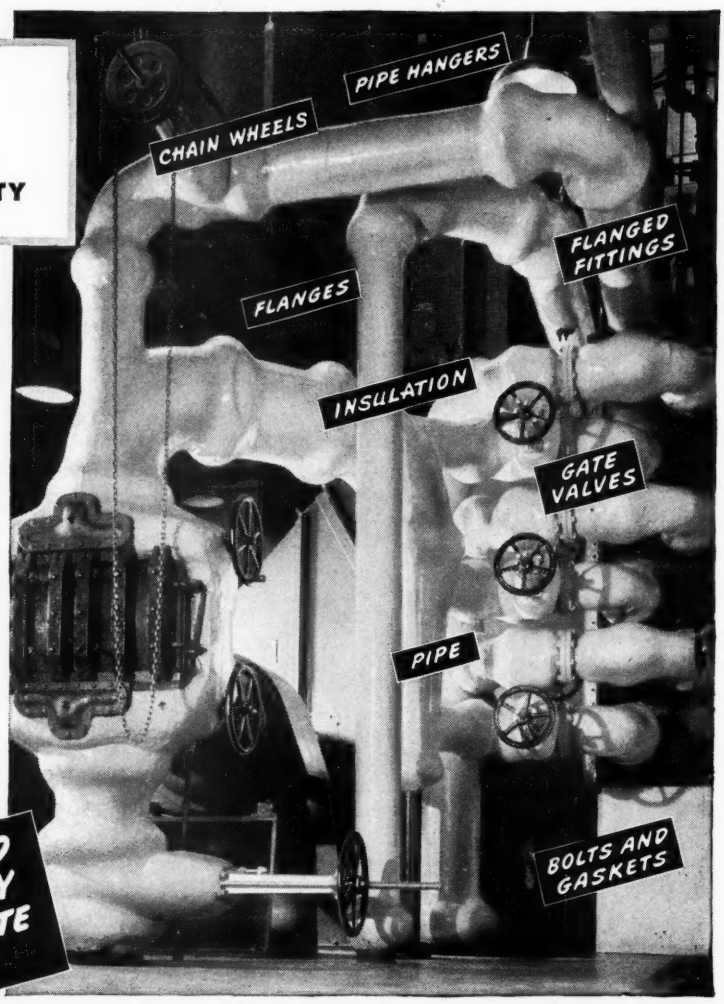
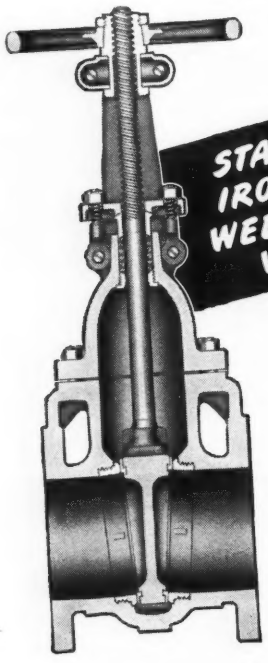


Water piping to air coolers



SERVICE RECOMMENDATIONS: Crane Standard Iron Body Wedge Gate Valves are suited for many services in factories and power plants, at all working pressures up to 125 pounds steam. Brass trimmed valves are recommended for steam, water or oil lines; all-iron valves for oil, gas or fluids that corrode brass but not iron. Made in O.S. & Y. and Non-Rising Stem patterns. See page 101 of your Crane Catalogue.

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Size of Valves	Screwed or Flanged Valves		Hub End Valves
	Saturated Steam	Cold Water, Oil, or Gas, Non-Shock	Cold Water or Gas Non-Shock
2 to 12 in.	125 pounds	200 pounds	200 pounds
14 and 16 in.	125 pounds	150 pounds	150 pounds
18 to 24 in.	*	150 pounds	150 pounds
30 in.	*	120 pounds	120 pounds

* For steam lines larger than 16-inch, Crane 150-pound Cast Steel GateValves are recommended. (For sizes under 2-in., use Crane Clamp Gate Valves.)

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, January, 1946 Vol. 23 No. 1

Health Insurance Awaits Taxing Decisions

ALTHOUGH very little was announced following the last Federal-Provincial Conference at Ottawa, it is obvious that no progress of a substantial nature will be made in furthering the federal health insurance proposal until the whole question of taxing rights and of tax allocation is settled. Although definite progress would seem to have been made in clarifying the taxing situation, there is still much doubt, even on the part of some of those provinces with a great deal to gain by the proposals, as to the ultimate result of such centralization of financial control. It would seem to be realized that the Federal Government has the right to collect the taxes in question—including income, succession and corporation taxes—but some of the provinces may be hesitating to agree to keep out of those fields, even though reimbursed by the Federal Government, in view of their prior participation. This problem of coordinating regional and national interests and viewpoints has long been a difficult one and it cannot be expected that a permanent and satisfactory solution can be found with ease.

Federal aid for provincial health insurance projects has been predicated upon the taxing structure adjustments. The period necessary for the working out of the extensive programmes announced in Manitoba and Saskatchewan will undoubtedly be materially affected by the availability or otherwise of these Federal funds. Mr. Douglas has already stated that the eight-year programme contemplated by his government could be accomplished within four years with Federal aid. Some of the provinces seem keenly interested in health insurance developments, while others have shown little interst. On one point, however, they are all agreed: if Federal subsidies are made available, each wants its full share but with complete freedom as to how it develops its own plan of health insurance. That regional variations are necessary is obvious, but we hope this does not mean a confusion of heterogeneous plans with no interprovincial recognition of benefits and perhaps with highly undesirable features or serious omissions.

Meanwhile assistance in hospital construction is bogging down badly. A year ago there was a widespread recognition across Canada that the provincial governments would need to augment private and municipal financial support if the increasingly serious shortage of beds were to be overcome. Provincial spokesmen were agreeing that something would have to be done and many fine provincial contributions for capital expenditure were being made. However, since Mr. Claxton referred to the serious bed shortage last summer and proposed low-interest federal loans to help correct this situation, this interest would seem to have waned. The provinces, which have always considered that health is their domain, are marking time and, of course, the Federal Government says it cannot make loans until the taxing revisions are approved. The net result has been almost a nation-wide holding up of planning for post-war hospital construction and building committees that were all keyed up to go on with a building programme are fast losing interest. Comprehensive health plans cannot be put into operation without adequate beds—and hospitals cannot be built overnight. A building programme must *precede* any extensive health plan providing hospital care. Unless private effort can be assisted, adequately and without delay, by the state—be it municipal, provincial, federal or, preferably, all three— in the construction of more hospital accommodation, the development of any such health insurance proposals must be relegated to the dim future.

The Greatest Modern Englishman

By W. HARGREAVES,
Vancouver, B.C.

THIS narrative is the modest tribute of a layman to the magnanimity of the greatest of modern Englishmen. The title may indicate some temerity on the part of the writer. But the phrase originated in "The London Times" which no one would rightfully charge with the misuse of a superlative. It was the concise eulogy, by a historian of current events, in admiration of the life and character of one who, had left to his profession a vision and fact of inestimable potentialities, and to mankind at large a common heritage of the wealth of happiness to be found in finer health and larger life: Lord (sometime Mr. Joseph) Lister, surgeon, Professor of Surgery at Glasgow, Edinburgh and London.

Joseph Lister, when young in years, became possessed of an ideal and, animated by a sublime inspiration, he pursued it to its ultimate culmination until that which he had idealized became the most beneficent actuality of our times.

Thrilled were we when we heard over the air-waves in 1940 the voice of Winston Churchill, "Never in military history did so many owe so much to so few". That sentence is destined to be a classic panegyric in the history of aerial warfare. It is an apt analogue to paraphrase those words with: "Never in the history of the whole human race did so many owe so much to one man", as we review the work of Lister, its efficacy in our times and the "Everlasting Yea" in the ages to come.

The impressive cogency of this phrase is elaborated in the words of Dr. John Stewart, Halifax, N.S., "There can be no doubt that, in the Providence of God, it was granted to Joseph Lister to do more to save life, to relieve pain, to obviate deformity and to prevent mutilation than any other man in the history of our race". This was not mere flattery of a brother surgeon. Rather was it the honest veneration of one who had lived and worked with Lister, had witnessed the great venture he was pursuing and had shared in the spirit that inspired his high endeavours.

Early Ambitions and Realities

It was in his early teens that Lister spontaneously expressed a desire to become a surgeon. After a course of preparatory study at University College, London, he suffered an illness followed by a nervous breakdown, but resumed his medical studies in 1848.

Lord Lister

As indicated by his young ambitions he became intensely interested in surgical operations. Yet, great as was his interest in any operation, his attention grew to even greater interest in the post-operative conditions of the patients of the wards. He was mystified and appalled by the inflammations, suppurations and gangrene that were common even after some of the simplest operations.

It seemed to him to be a matter of chance whether the patient lived, suffered in deformity, or died. It is on record, so great was the anguish, that he questioned the wisdom of his teachers to use the knife except in cases of extreme necessity.

Pre-Listerian Hospitals

The altruistic spirit of mankind had said, "There shall be hospitals" and hospitals there were all over the civilized world. But, in the age-long pre-Listerian era, what hospitals! Dr. Clifford Allbut when writing about that period said "Patients dreaded the name of hospital and the most skilful surgeons dreaded their own craft". Fear, despair, terror amongst the people; dread amongst the surgeons. Why?

The institutions intended to be those of healing and hope to the casualties of disease or accident were, on the contrary, houses of terror and despair. To be afflicted by a surgical ailment and taken for hospital treatment was in general public estimation the penultimate stage to the grave. A premonition of torment, deformity,and death was linked with the name of hospital.

Pestilence that Walketh in Darkness

This state of mind, common alike to the people and the surgeons, was not primarily due to surgical operations; it was because of that all-pervading pestilence that attacked the patient after the operation.

There were great surgeons in those days whose names have become classical in surgical history and who, while building honoured reputations, were enlarging the science of their profession. Yet a considerable portion of their work was nullified and the advancement of their science was circumscribed by the prevalence of obscure factors which were undefined and actually up to that time had been deemed undefinable.

Those hidden factors were in universal evidence, manifested by what was ambiguously termed "Hospital

Diseases". The hospital diseases were the besetments of surgical cases, post-operative complications distinct from the original complaint afflicting the patient. Hospital diseases were something acquired within the hospital. What the cause of that something or whence its source no one knew. Every wound, whether caused by accident or due to an operation, became a suppuration. Gangrene was rife in all hospitals at one time or another and by its repulsive mortification became a horrific culmination to otherwise successful surgical craft.

Universality of the Pestilence

The larger proportion of surgical patients in those days were accident cases. Many of them became amputation cases, though all too frequently such amputations were not due to the accident, but more often were because of the acquired hospital disease.

The mortality rate was high in all countries. A London hospital with a surgical mortality rate of 26 per cent was considered one of the best, and this rate deemed "satisfactory". Statistics of surgical mortalities were:

Pennsylvania	24 per cent
Glasgow	39 per cent
Edinburgh	43 per cent
Vienna	43 per cent
Zurich	46 per cent
Paris	58 per cent
Munich	85 per cent
Military Hospitals	75 to 90 per cent

Nuremberg Hospital had been abandoned as hopelessly impossible. It was said truly that the soldier in the Crimean War had more chances of safety on the battlefield than he had of recovery from wounds in the hospital. That was where Florence Nightingale received the shock of her life as she witnessed the misery and suffering of the wounded.

The Hospital That Was

Bacteriology as a science was not yet born. The term "germs" covered the whole field of miscroscopic organisms. Germs had been observed under the lens, but the significance and classification of them had not been determined. Certainly the relativity of germs to those noxious hospital diseases had never been considered.

The procedures at the University College Hospital—where Lister first studied—were practically those common to all better hospitals.

The operating room was a small room furnished with a wood table, a wood cupboard for instruments, a wood stand with a dish containing sea sponges and a jug of water, this stand also being used as the instrument table. The room was lit with a gas jet.

Preparatory to an operation, the surgeon donned an old frock-coat discarded for street and office use, such being deemed the mode — the more messy the more modish.

During the operation the surgeon and patient would be surrounded by as many students as could get into the room, many of them clad in raiment soiled by routine work.

For the ablutions of the staff and the patients a few jugs of water were provided with, in some instances, nothing more potent than a dash of Condy's Fluid. The same was used for washing the instruments. A probe —to keep open a suppurating wound —would travel around the ward from patient to patient with no other cleansing.

Most of the patients in the wards were in varying stages of pain and even mortification. Odorous gangrene was considered to be an ordinance of fate, and any recovery by a patient after an operation was as a lottery decided by the ever present pestilence.

The dread of the surgeon limited the scope of his science and art. Abdominal surgery was uncommon; clinical diagnosis barely explored. Thoracic surgery was a rarity. The spinal cord and cranial cavity were undeterminate. The deformed—even from birth—were doomed to struggle through life with twisted limbs, bow legs, knock knees, club feet, and distorted features, because surgical treatment would but pave the way for hospital disease.

Pestilence stalking through all hospitals, hovering beside all accident and surgical patients, mystery everywhere. Defeat of surgical skill; frustration of nurses' care; negation to the most beneficent hospitalization—all these were adjuncts of the deadly host. That is the terse picture in sombre tones and darker shadows. A couplet in Omar Khayyam's Rubaiyat depicts the prevalent mystification and negation:

"There was a door to which I
had no key,
There was a veil past which I
could not see."

Operating Room at South London Hospital

And then Came Lister!

Subsequent to his term in London he went to Edinburgh for post-graduate experience. There were surgeons of great repute in Edinburgh, amongst whom was Professor Symes who was said to be the most original surgeon in Europe; certainly he was considered as the head of his profession in the British Isles. Lister's intended temporary post-graduate course progressed so rapidly and extensively under Symes, that he was offered a permanency as clinical lecturer at Edinburgh University. His clarity and ability attracted the attention of other schools and at the age of 32, after seven years in Edinburgh, he was invited to be Professor of Surgery at Glasgow University.

While in Edinburgh he was married to Symes' daughter Agnes. An episode at the wedding is worth recording. When Agnes Symes was a little girl she had suffered a serious illness during which she was totally unconscious for four days. At the wedding breakfast Dr. John Brown, author of "Rab and His Friends" proposing a toast said, "Joseph Lister is one who will go to the top of his profession. As for Agnes she was once in heaven for four days and she has borne the marks of it ever since". Could anything more beautiful be said of a lady's graces!

Glasgow, A.D., 1860

It was during Lister's course of studies in London "walking the hospitals" that the morbid conditions in the wards first touched his sensitive soul. There he first witnessed the malignant effect of the insidious mystery. When he moved to Glasgow he had entered an industrial area where accidents in the shipyards, docks and factories were more numerous. Consequently his surgical cases at the Royal Infirmary also were more numerous *pari passu,* the septic cases were more frequent. From his student days this problem of sepsis that overshadowed the hospital world became his daily concern and was becoming more and more acute with the changing venue of his work and the enlargement of his responsibilities.

Plato has said "Before the world came into being as a fact of creation, it had a prior existence in the Divine Mind as an idea." A similitude would aptly typify Lister's idealism and the pursuit of his self-ordained task. "Before aseptic surgery came into being as a universal system it had a prior existence in Lister's mind as a Divine Ideal". It was with the ardent zeal of such an inspiring motive that he bent all his studies and energies to find the answer to the problem. The immensity of this purpose—freedom from sepsis, freedom from the daily ravages and incalculable toll of the pestilence—can scarcely be comprehended by us who are heirs of his beneficence. The grandeur of his self imposed mission can only be visualized by comparing present-day liberations with the thraldom of those pre-Listerian ages.

It is recorded that on one occasion, while making the hospital round with his students, a case of fracture with contusion was brought in. Preparatory to setting the broken leg he pointed out to his class "If the fracture be set without damage to the skin, recovery is sure. But to break the bruised skin while setting the limb would imperil the life of the patient."

This illustrates that he had arrived at a triple postulate:

1. Infection occurred when there was an open wound or broken skin;
2. Infection manifested itself by suppuration;
3. Suppuration occurred from decomposition, with gangrene as the pen-ultimate aggravation, only preceding amputation or death.

Yet the primary causes remained behind the veil.

Auspicious Episode—Pasteur

There came a day, auspicious and eventful. Lister on that day was discussing his problem with Dr. T. Anderson, professor of chemistry. When Lister had reviewed the stages of his investigation and his deductions, Dr. Anderson remarked that a chemist in Paris had just published some remarkable discoveries. Lister obtained a copy of this report.

It had happened that the wine-grape growers of France were having trouble with their wines turning sour. As a result instead of wine it was more like vinegar. They appealed for help to the Chemistry Institute of Paris. The chemist therefrom investigated and found that the open wine vats had permitted the entrance of foreign matter. Some of this foreign matter he found to be alive. As a conclusion

(Continued on page 82)

Rev. Hector Bertrand, S.J. President Catholic Hospital Council

Rev. Father Hector Bertrand, S.J., has been named President of the Catholic Hospital Council of Canada, succeeding Rev. Sister M. Berthe Dorais, s.g.m., who has been President for the past few years. Sister Dorais, who so efficiently carried out the responsibilities of this office during the formative period, will remain as First Vice-President. The offices will be at 325 St. Catherine Road, Montreal.

The membership of the C. H. C. of C. is as follows:

President: Rev. Father Hector Bertrand, S.J., Montreal.

First Vice-President: Sister M. Berthe Dorais, s.g.m., Montreal.

Second Vice-President: Mother M. Ignatius, Antigonish, N.S.

Third Vice-President: Mother Audet, Sorel, Que.

Secretary-Treasurer: Sister M. St. Elizabeth, London, Ont.

Members:

Sister Cecelia Clermont, Vegreville, Alta.

Mother Marguerite Mann, St. Albert, Alta.

Sister Gertrude, Vancouver, B.C.

Sister M. Claire, Victoria, B.C.

Sister M. Auxilia, Grandview, Man.

Mother Anne Trottier, St. Boniface, Man.

Mother M. Francis Loyola, Charlottetown, P.E.I.

Mother M. Margaret, Toronto, Ont.

Mother Ste. Jeanne de Chantal, Quebec City.

Sister Ste. Gertrude, Quebec City.

Sister Marie de Loyola, North Battleford, Sask.

Sister Jeanne Mandin, Saskatoon, Sask.

The South London Hospital

By DORA DIBNEY
Regina

LESS than 100 years ago Elizabeth Blackwell obtained a degree as medical doctor. To reach that goal Miss Blackwell had to overcome almost insuperable obstacles, mostly due to prejudice against women entering the profession. It is a far cry from that day to the present when hospitals are entirely staffed by women.

Such a one is the South London hospital for women and children, founded by Miss Maud M. Chadburn, C.B.E., M.D., B.S., pioneer, senior surgeon of the hospital from 1913 to 1933, and still actively associated with the administration of the institution.

The South London Hospital is located on Clapham Common, the site being chosen because there was no hospital solely for women on that side of London. The only other of its kind was on Euston Road.

Miss Dibney is Editor of "The Saskatchewan Farmer" and is a Past-President of the Canadian Women's Press Club. She was in England last summer.

The hospital was founded and incorporated in 1912 with the following objects: to meet the great and growing demand on the part of women for medical treatment by members of their own sex; to provide in addition to ordinary hospital accommodation, private wards for women of limited means; to afford further scope for post-graduate training for medical women.

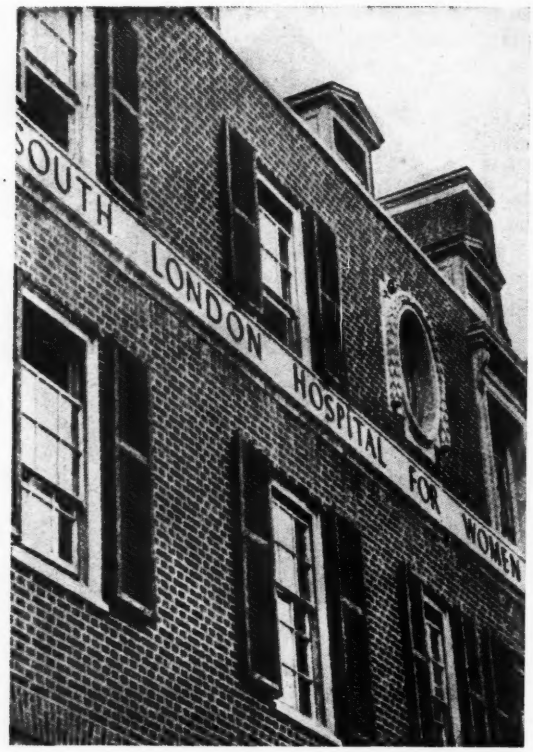
On the outbreak of war in 1939, regulations were changed to permit hospitalization of men, and according to the report for 1944, referring to in-patients, " . . . on the instructions of the ministry of health from June to the end of October, admissions were restricted to acute civilian emergencies, air raid casualties and service cases".

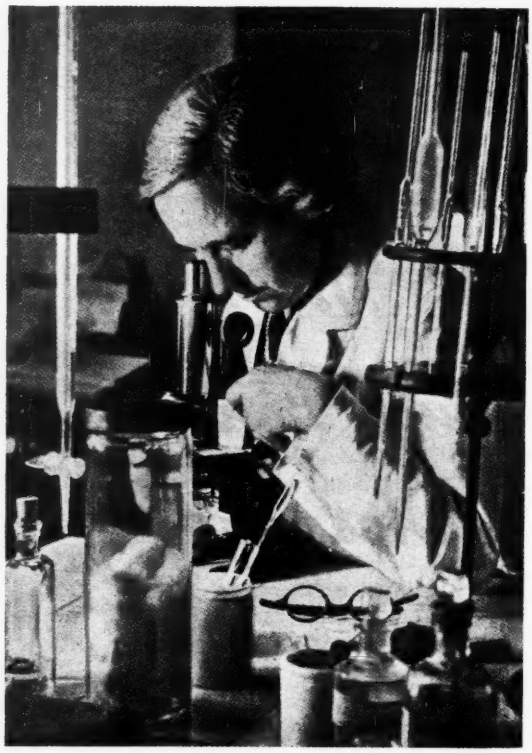
Remedial Gymnastics

More than 550 casualties were admitted to the wards, 479 during June, July and August, when South London suffered so severely from flying bomb raids, and in addition 367 were treated for minor injuries.

Fortunately the hospital building itself escaped serious bomb damage, although time and again all the windows were shattered by blast from nearby explosions. One corner was ripped from the nurses' home, but temporary repairs were carried out so that the building continued habitable.

Wards are bright and sunny, with flowers on every centre and bedside table. Operating theatres are modern marvels of efficiency. All diseases are treated at the South London with the





exception of acute infectious fevers and mental diseases. Special departments include ear, nose and throat, ophthalmic, orthopaedic, urological, venereal diseases, skin, pathological, x-rays, electrical massage and dental, also a special radium clinic for treatment of cancer in women.

Professional standing of the hospital is extremely high, with the medical officers and consultant staff, all women, working together in harmony and with great efficiency. The yearly report pays well-deserved tribute to the matron, Miss S. C. Evennett, and her assistant, Miss A. L. Barnard, and all on the nursing staff.

Tremendously heavy demands on the resources of the hospital and its staff were inevitable during the war years. New maternity wards were opened and this despite shortage of help, the increasing number of patients admitted for treatment due to raids, and the nerve-racking night-flying bomb attacks which went on for week after week.

The board of management, under the chairmanship of the Hon. Mrs. Murray, meets frequently to carry out the duties of administration. In 1936 the board decided an extension was essential, and work was begun. Only part of the scheme could be carried out before war compelled cessation of the building programme. New operating theatres were completed in 1936 and new pathological laboratories opened the following year. Increasing demand for women doctors is shown by the great expansion in the hospital services during the years. Patients from all the London boroughs, from many parts of England, from Wales and from Ireland, seek admission.

Certain it is that thousands upon thousands of British working women are deeply grateful for the kindness and courtesy shown and the expert medical and surgical care given by the South London hospital staff.

Nursing Sisters May Defer Use of Rehabilitation Grant

Following the meeting of the Canadian Hospital Council last September, a resolution was forwarded to the Minister of National Defence, urging that the Federal Government should permit returning nursing sisters who desire to take post-graduate courses to postpone this utilization of rehabilitation funds for up to three years from the time of discharge, and that the granting of such postponement of rehabilitation aid be made contingent on the nurse being employed in the interval in that field in which she proposes to specialize.

Following is an excerpt from the reply received from the Honourable Ian Mackenzie, Minister of Veterans' Affairs:

" . . . I am pleased to tell you that the present regulations permit deferment, for good reason, in individual cases. Graduate nurses should, therefore, submit their applications for post-graduate study as soon as possible after discharge, and not later than twelve months after discharge, requesting, at the time of the application, deferment of the date upon which study should begin. It would be important, in such cases, that the reasons for deferment be elaborated and substantiated by supporting documents. Each individual request for deferment would then be considered upon its merits."

Statement by President Arthur J. Swanson

Canadian Hospital Council to Have Full-Time Secretary

THE Canadian Hospital Council will now have a full-time secretary and editor. This was agreed upon at the Hamilton meeting of the Council last fall, but before definite action could be taken or announced a number of relevant factors, including that of finance, had to be considered and clarified. This arrangement became effective on January first of this year.

It has been very apparent that the work of the Canadian Hospital Council has so expanded that only the services of a full-time secretary could meet the situation. With the growth of "The Canadian Hospital", steadily increasing demands are being made upon him as editor of this magazine. From its inception the Canadian Hospital Council has been assisted materially by the Canadian Medical Association through its Department of Hospital Service which, in turn, was assisted by the Sun Life Assurance Company of Canada. The initial meeting of the Council was called by that body, the Council has been housed free of rent by the C.M.A. and, for quite a few years, the C.M.A. Department of Hospital Service provided free of any charge the services of the secretary and his staff, office equipment and supplies, the printing of bulletins, the secretary's travelling expenses, etc. Within a few years the expenses became such that the associations were asked by the Council executive to make annual contributions. This was done at once (1935) and the augmented funds have enabled the Council to meet the increasing demands for its services.

Now, facing a post-war expansion and re-organization of the work of the Canadian Medical Association, it has seemed to the executive committees, both of the Canadian Hospital Council and of the Canadian Medical Association, that the time would appear to have arrived when our national hospital organization should leave the parental roof and stand on its own. This decision has now received the approval of both bodies. The Canadian Medical Association will discontinue the Department of Hospital Service, organized in 1928 when there was no co-relating body between the then existing hospital associations, and will turn over to the Canadian Hospital Council its extensive files on hospitals and on activities related to hospital work, its Blackader reference library of hospital publications and the Department of Hospital Service equipment. One or two of the activities of that Department which were essentially related to medical education will probably remain with the Canadian Medical Association.

Dr. Harvey Agnew, who has been secretary of the Department and of the Council since each was organized, has elected to go full time with the Canadian Hospital Council and will sever his connection with the Canadian Medical Association early in the new year. The new address of the Council, after January 15th, will be 280 Bloor Street West, Toronto.

It was realized at the Hamilton meeting that this development will require increased finance. The delegates were agreed, however, that this obligation would be met willingly by the hospitals of Canada. A special finance committee, under the chairmanship of the President and with every part of Canada represented, is now working out a basis of contribution which will be fair to all. In anticipation several of the associations have either raised their contributions or have given their execuitves authority to take the necessary action.

After attending the Hamilton meeting of the Canadian Hospital Council and the Chicago meeting of the House of Delegates of the American Hospital Association, it would appear that we must be prepared for a greatly expanded programme during the coming years. The problems presenting themselves will require careful study, not only by your officers but by special committees which may be set up, if the ideal solution is to be found for them. I feel that we are going through a period of very great readjustment, and that it is by the closest attention to legislation affecting hospitals which may be brought down, and to other problems which are burdens for the hospitals in many parts of the country, that the Council can be of real service to the provincial and other hospital organizations and to the individual hospitals of all affiliated groups.

It is our desire to assist in every way possible in finding a solution to these problems as they present themselves; to this end I am looking forward with the keenest anticipation to the full co-operation of all groups within the Council.

It is with the most sincere regret that we realize that the services of Dr. George F. Stephens are not available to the Council owing to ill health. He was a tower of strength in all the activities of the Council and his intimate contact with the many governmental bodies at Ottawa meant a great deal to the Council as a whole. It is our sincere hope that he will soon be returned to full health and strength again and be able to resume his activities with us. I think that he has set a very high example for us to live up to and, for my part, it will be my desire to follow along the lines laid down by Dr. Stephens during the years he was President of the Council.

Arthur J. Swanson.

Pre-Convention Administration Course Draws Large Attendance

THE largest convention yet held from the point of number and one that has probably not been excelled in interest of programme was the 28th annual meeting of the British Columbia Hospitals Association held in Vancouver on November 21 and 22 under the chairmanship of Dr. T. W. Walker of Victoria and with Mr. E. W. Neel of Duncan as secretary.

The meeting was preceded by a two-day hospital administration course which was almost as well attended as the convention proper. Almost all of the administrators and secretary-managers in the province were registered. Lecturers on the first day were Mr. Percy Ward, chief inspector of hospitals, Mrs. Edith Pringle, Reg. N., also inspector of hospitals, and Mr. W. N. Miller, former inspector of accounting and now administrator of the Crippled Children's Hospital. Topics were "Admitting and discharge procedures" and "Co-ordinating the viewpoints of both the superintendent of nurses and the business manager".

"Environmental sanitation problems about the hospital" was the topic of Mr. R. Bowering, public health engineer. Dr. W. H. Hatfield, medical director of tuberculosis control, discussed "Tuberculosis and the General Hospital". Major W. C. Mooney, provincial controller of venereal disease, spoke on that problem as it involved hospitals and Mr. O. A. Petersen, personnel manager of the B. C. Electric, considered "Personnel management". The second afternoon was devoted to a three-hour round table led by Dr. Harvey Agnew.

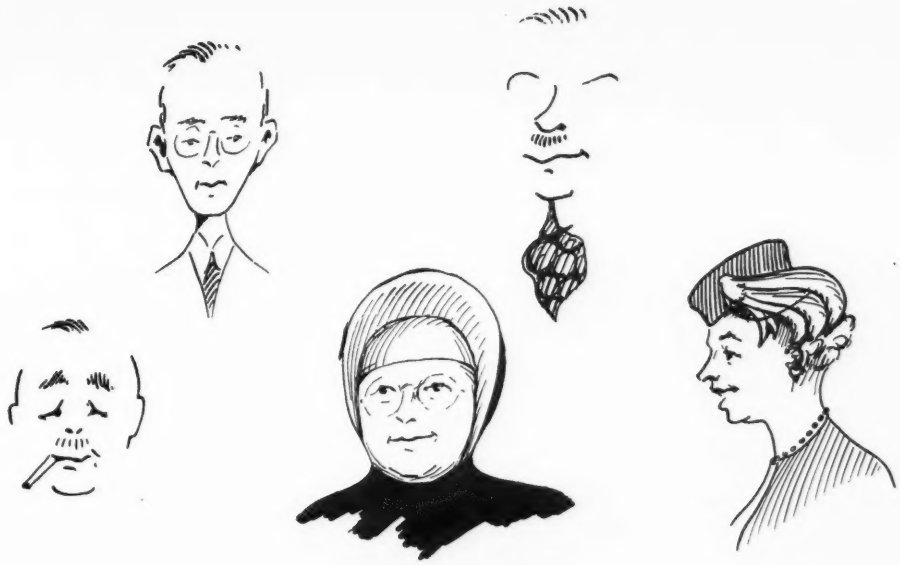
This is the second year for this pre-convention administration course and it has proven to be an excellent innovation. British Columbia is fortunate in having such an array of clear thinking and progressive government officials, all of whom are excellent speakers. They helped materially to make the course a success.

In his presidential address Dr. Walker stressed the need for more and better accommodation for the

Celebrities at the British Columbia Meeting

Upper: Percy Ward, Chief Inspector of Hospitals; Secretary E. W. Neel of Duncan; A. McLean of North Vancouver—about to join Mr. Ward's staff.

Lower: E. S. Withers of New Westminster; Retiring President Dr. T. W. (Hiram) Walker of Victoria and Past-president S. M. Cosier of Kamloops.



More Celebrities

Upper: W. N. Miller, Crippled Children's Hospital, Vancouver; A. H. J. Swencisky of Vancouver, formerly Treasurer, now a Vice-president.

Lower: Charles Morrison of Victoria; Sister Columbkille of Vancouver, President of the B.C. Conference, C.H.A.; Mrs. Edith Pringle, Reg. N., Inspector of Hospitals and ace lecturer.

chronically ill, pointing out that if a general hospital has fifty chronic patients and if we assume a minimum turnover of at least 20 "active" patients per bed annually, these fifty chronically ill patients would keep 1,000 average patients from using those beds. He asked for a policy of co-ordinated aid which would provide where it would be most needed. He hoped any hospitals for chronics to be built would not be modelled after the old poorhouses.

Mr. Neel in his secretary's report noted that while all hospitals on the Island are now getting $3.50 per diem for the care of Indians, all on the mainland excepting some of the larger ones are only getting $3.00. A satisfactory explanation has not been furnished. He made reference to the statement that the British Government proposes to take over all hospitals and was certain that no one would like to see that done here.

The nursing session under the chairmanship of Sister Mary Columbkille, Reg. N., of Vancouver, provided some excellent addresses and fruitful discussion. Speakers included Miss Braund and Miss Wright of the Registered Nurses Association, Mrs. Desatge of the Canadian Red Cross, Sister Mary Gregory and Miss Lena Mitchell of Victoria, and Miss Watkins of St. Paul's Hospital. Dr. Harvey Agnew spoke of recent changes in organization and financing in the Canadian Hospital Council and discussed a number of present day developments affecting hospitals. The summaries of regional activities revealed much progress and interest. Other speakers on the programme included Mr. Joseph McKenna of Victoria, Alderman Jones of Vancouver, Mr. E. S. Withers of New Westminster and Treasurer A. H. J. Swencisky of Vancouver.

President J. V. Fisher of Victoria

The incoming President who, as a side-line, is Deputy Minister of Finance, confides that he leaves all major decisions to the "bones".

Resolutions and motions urged more action on the part of municipalities and the province towards providing more hospital accommodation, particularly for chronically ill patients, and increased hospital grants to meet rising costs; the licensing of practical nurses and approval of the Red Cross Society plan for blood transfusion services. The contribution of the Association towards the maintenance of the Canadian Hospital Council was doubled.

Officers

Honorary President: The Hon. George S. Pearson.

President: J. V. Fisher, Victoria.

1st Vice-President: K. K. Reid, New Westminster.

2nd Vice-President: A. H. J. Swencisky.

Treasurer: F. W. Nesbitt, Oliver.

Secretary: E. W. Neel, Duncan.

Committees:

Medical Affairs: A. K. Haywood, M.D., Vancouver.

Business Affairs: Charles Morrison, Victoria.

Nursing Affairs: Miss Elinor Palliser, Reg. N., Vancouver.

Constitution and By-laws: Joseph McKenna, Victoria.

Regional Affairs: E. S. Withers, New Westminster.

Better Provision Needed for the *Chronically Ill*

President Walker Urges Consideration

THERE are many beds in active treatment hospitals that are taken up by chronic cases, who do not need specialized care. Another year has passed, leaving with us our perennial problem of what to do with such cases. Valuable beds are being sacrificed to give care to patients who need very little active hospital care. There are too few "homes" for this group.

At the present time the following is the condition of affairs in three of our larger hospitals:

Vancouver General Hospital: 44 patients, who could to advantage be moved to an institution for the care of chronic patients. In addition there are 203 chronic patients in institutions operated for chronics by this hospital.

Royal Columbian Hospital: 30 men and 8 women, who could be cared for in an institution for the chronically ill.

Royal Jubilee Hospital: 24 men and 18 women, who do not need active treatment and could be cared for in such an institution.

Municipalities refuse to assume the responsibility and expense of providing for them, except in a very small way. The Government has not prescribed any plan for the solution of the problem. Hospitals have not the power to force action, so the condition has persisted and persists. Surely there must be some power with teeth in it to solve the simple problem. The taxpayer is paying twice too much at the present time for chronic cases. Active treatment beds cost at least $5,000 to build and over $4.00 a day to maintain.

Perhaps we are approaching this problem from the wrong angle. The chronically ill need care. The number of chronics is bound to increase. The low birth rate of some years back has made it certain that the number of middle aged and aged will increase in the near future and the use of penicillin and the sulpha drugs is prolonging their lives, so that they will live much longer than has been the case even in the past decade. The science of geriatrics, that is the study of the diseases of middle and old age is bound to be a very important one—so important that it will compel recognition. A general active treatment hospital is the logical place to have these cases classified and categorized. Therefore a wing attached to such a hospital or in its neighbourhood would be the logical place to put them. This would save in duplication of services. Patients are bound to pass frequently from an acute to a chronic condition and back again. The transfer, so far as hospitalization is concerned, could be made quickly and economically. The chronic section of a hospital, stripped of the heavy expense of x-ray and operating room service, could be operated by a general hospital as cheaply and more efficiently than by any other service, and without the diagnostic facilities required if a separate clearing house were established. It is true that some arrangement might be necessary for the hopeless cases. If a general hospital has 50 chronic cases constantly attached to it, and if we concede that a bed in an active treatment hospital is turned over 20 times a year, then 50 chronic cases would take the place of 1,000 active cases. This is a serious condition when active treatment beds are at a premium.

From the Presidential Address of Dr. T. W. Walker at the B.C. Hospitals Assn. Convention.

A. C. S. Lists Approved Surgical Training Plans

Chiefly as an aid to medical officers returning from war duty, the American College of Surgeons has published a 424-page directory in which are listed and described the approved programmes of graduate training in surgery in 240 civilian hospitals in the United States and Canada and a number of American naval, veterans' and U. S. P. H. S. hospitals. The total number of approved training plans in the 289 hospitals is 228 in general surgery and 522 in the surgical specialties. In these 750 training plans approximately 2,000 surgeons may be trained whereas, as the College points out, training facilities for at least 5,000 are urgently needed for returning medical veterans whose training in surgery was interrupted by their military service. This list includes four openings in Ontario and four in Quebec. (Additional residencies and fellowships available to returning medical officers are listed in the booklet "Facts about your Medical Career on Demobilization" issued by the Canadian Medical Procurement and Assignment Board, Elgin Building, Ottawa.)

The descriptions of the approved programmes include information about the size and type of hospital, organization of the medical staff, facilities for study of the basic medical sciences in their application to surgery, library facilities, clinical material, manner of selecting individuals for training in surgery, scope and method of surgical training, supervision by the medical staff, examination and thesis requirements and provision, if any, for conferring higher medical degrees.

Dr. Dallas B. Phemister of Chicago is chairman of the Committee on Graduate Training in surgery of the American College of Surgeons, and Dr. Malcolm T. MacEachern, Associate Director, is in general charge of the department.

New D.V.A. Publication

The Department of Veterans' Affairs has introduced a semi-monthly publication "for telling the story of the rehabilitation programme, for interpreting the legislation, and for discussing the philosophy of its administration".

How Much Hospitalization *is Really Necessary* for the Chronically Ill?

By PERCY WARD,
Chief Inspector of Hospitals and Institutions (B.C.)

LAST year this department was asked to give assistance in finding alternative placement for a number of chronic cases in general hospitals. Quoting from the 1944 report on "Hospital Statistics and Administration of the Hospital Act" we note that

> **"of 142 problem cases arising in hospital, 40 were satisfactorily placed in their own homes, or with friends or in private boarding or nursing homes; while 102 were sent to institutions, indicating that, by careful study of individual cases, many social problems can be satisfactorily handled by assisting friends and relatives, and our institutions can be relieved to a major extent by adequate and efficient social and medical social work. In addition to the 40 cases enumerated above, 32 cases made their own arrangements, following assistance and advice either by social workers in the hospitals or as a result of assistance and advice from this office and members of the Field Service Staff of the Social Assistance Branch."**

The term "chronic cases" used in the discussion generally means persons who have ceased to need acute hospital care. These people cannot properly be classified under any one term. Many terms would be necessary to encompass them all. In fact no two cases are exactly alike, and no one solution can possibly apply to them all.

As various illustrations were discussed on Monday in the lectures and questions regarding "Admissions and Discharges", I do not propose to give illustrations now, but you are asked to note, first, that hospitals do not refer hospital clearance cases to the department unless they are problems which the hospital has been unable to solve without assistance. Remembering this, nearly one in every three of the difficult problem cases we have been able to assist in placing, have been placed either in their own homes or in other private establishments, and with advice and assistance, one in four have been able to make satisfactory arrangements for themselves. In other words, this indicates that of the hospital problem cases referred to the department a large number can be satisfactorily placed without going to a central institution at all, and this notwithstanding the tremendous pressure of housing accommodation existing as a result of the war.

As you know, these problem cases are numerous now. I suggest to you that their numbers will increase progressively and that to cope with these problems all those concerned—hospitals, voluntary organizations, municipalities and the Province—will each have to do their part. Insofar as these problems arise in hospitals, it appears inevitable that hospitals, in their own defence if for no other reason, will find it advisable to expand existing hospital social service departments; to instal them where they do not now exist, and to recognize medical social service as an essential to an efficient modern general hospital.

I submit to you there is much that the hospitals can contribute towards the solution of this "chronic case" problem. But, of course, there are limitations to what the hospitals can do.

If we keep in mind that these chronic cases are of all types, we will see that there will have to be many different institutions, and at least several classes of institutions to care for them adequately. Ambulatory cases which have to be institutionalized can and should be cared for in their own home towns as far as this is possible. Central institutions should be reserved for those cases requiring special care and treatment and where special equipment and specialists are necessary. It is not economically sound or even sensible to secure and maintain specialized equipment and the services of specialists except in an institution catering to a very large population.

It may be that a central Provincial authority may develop the specialized central institution, but advance in providing local institutions is more likely to develop to meet the need if the local areas themselves accept the responsibility for taking the initiative, with perhaps some assistance from a central Provincial authority.

It is very common and so easy to say the Provincial Government should do this or do that. But it is well to remember that if the Provincial Government accepted the responsibility to construct and to control everything it is asked to construct and control, it would not be long before local autonomy would gradually fade away, and voluntary charitable organizations and voluntary hosptals would begin to disappear.

From an address given at the B.C. H.A. convention in Vancouver in November.

Dr. A. F. Anderson Injured

Dr. A. F. Anderson, superintendent of the Royal Alexandra Hospital in Edmonton, is making a satisfactory recovery from an injury sustained on November 28th, when he was struck by a truck not far from the hospital. Fortunately the truck was proceeding slowly, or the accident might have been more serious. Dr. Anderson was thrown rather heavily and sustained a fracture of the hip. He has been given an excellent prognosis, although he will be confined to bed for some weeks. Within a few days of the accident he was "back at work" directing the activities of the hospital from his bed.

Montreal Military Hospital

The Old Becomes the New

By COL. J. C. MACKENZIE, R.C.A.M.C.
and MAJOR L. E. SHORE, R.C.O.C.

IN June of 1944 it was decided that the Army should extend its general hospital facilities in order to provide some 2,000 additional beds throughout Canada. This figure was determined only after a very complete and careful survey of the military bed requirements for each military district, and included a safety cushion of 25 per cent additional beds.

As speed was the keynote to the completion of this whole programme, all concerned with its implementation were charged with making this assignment their only pre-occupation. The highest priorities were assigned in the obtaining of building materials, labor and equipment. To further ensure the greatest possible speed it was decided that existing military hospitals would be increased in size, and that buildings then in use for other purposes and considered suitable for hospital purposes were to be converted to provide hospital facilities rather than to build new hospitals *per se*.

As an example of how an existing building was converted to a good and adequate modern general hospital providing 800 beds with a crisis expansion to 950 beds, it is proposed to describe briefly the Montreal Military Hospital.

The Adaptation of an Existing Building to a Modern General Hospital.

Montreal Military Hospital

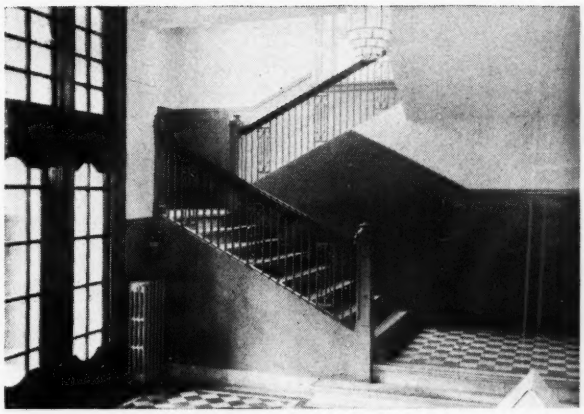
The building selected had formerly been a school (Nazareth Institute), so there were many large class rooms which permitted of ready conversion to ward accommodation with a minimum of reconstruction. The building, which was erected in 1931, is of excellent construction, having a reinforced concrete frame with exterior brick walls trimmed with stone. It consists of a basement of one-half floor, a ground floor and five complete storeys. In addition there is a well-equipped and adequate powerhouse housed in a separate building.

The main approach to the hospital, from its own driveway off Queen Mary Road, is used almost entirely for visitors and staff, as there are separate outpatient and Admission entrances in the rear of the building.

From the main entrance enclosed stairs lead up to the second floor, which is used mainly for administrative offices. In the Entrance Hall there is ample waiting space for visitors and the Information Desk and Telephone Exchange are located here. The main corridor runs off this hall at right angles.

Due to the fact that all floor surfaces throughout the building are of Belgian tile, corridor traffic was bound to be exceedingly noisy.

Colonel Mackenzie, prior to enlistment, was general superintendent of the Montreal General Hospital, and will shortly set up practice as a hospital consultant in Montreal. Major Shore is a B.Arch. and M.R.A.I.C., and has recently set up practice under the firm name of Shore and Moffat, Architects, Toronto.



Central Entrance and Stairway

Information Desk

Accordingly the corridor ceilings were furred to permit the installation of acoustic blocks, which considerably deadened all traffic noises. It also concealed the additional wiring and plumbing that had to be installed.

On this main floor is a large Auditorium with a seating capacity of 500, equipped with an excellent stage and an up-to-date, fireproof projection booth. When not in use for stage shows and movies it becomes a Lounge and Recreational Centre for, off it but forming part of it, are writing rooms, a quiet room and a canteen. The east end of this floor provides two wings of 45-bed and 46-bed capacity each, while the west end comprises a 48-bed wing.

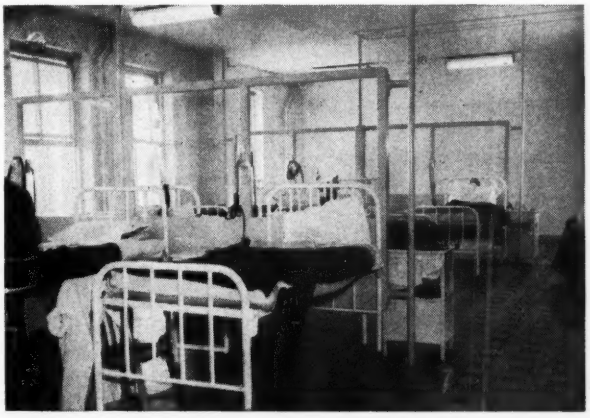
The typical Ward Wing is of 46-bed capacity, but this is split into separate wards of 20 to 25 beds, with one or more (usually two) isolation rooms per ward. Each ward has its own complete complement of solarium, patients' wash rooms and toilets, nurses' wash rooms and toilet, utility room, ward kitchen, nurses' chart room, doctor's consultation room, examination and history room, visitors' waiting room, etc. The kitchens are of ample size and well equipped, and the utility rooms have the standard equipment. General illumination for the wards is by fluorescent lights; in locating them care was taken to ensure that no direct glare could annoy the bed patient. The lighting fixture selected is in itself guarded against angle glare.

In order to obtain the maximum bed capacity it was decided,on account of the depth of rooms, to divide them into bays by means of dwarf, glassed-in partitions. In planning these partitions, care was taken to ensure that, wherever the existing contours would permit, they would not run right up to the subtending walls, but would stop three feet from them, thus allowing a nurse or attendant to walk round either end of the partition.

Installed in the partitions opposite the end of each bed is a double utility outlet and a nurses' call signal system. The advantage of the double utility outlet is that it permits the use of a bedside lamp and any piece of additional equipment used for therapeutic purposes, a radio, etc.

Immediately below this *second* or Administration Floor in the centre wing are the Patients' Dining Rooms and Main Kitchen. The remainder of the space is taken up by typical wards which occupy the whole of the east wing and half the west wing. The other half is the Officers' Mess with anteroom and dining hall, used as a joint mess by medical officers and nursing sisters. This is a complete unit with its own kitchen.

The airy Main Kitchen measures about 2,600 square feet and contains all modern equipment and mechanical



A Typical Large Ward

Cafeteria for Up-Patients

Admitting and Discharge Department

One of the Operating Rooms

aids. Off it are the dietitian's office, bakery, stores, dishwashing room, etc., and a bank of walk-in refrigerators with especially large meat compartments. In this kitchen all meals for ward and ambulatory patients and staff are prepared. Food is sent to the wards in electrically-heated food conveyors. By means of special outlets placed at strategic locations on the wards, it can be kept warm during the serving. Adjacent to the main kitchen are the cafeteria and dining rooms where up-patients obtain their meals.

The central wings in which the main elevator is located have in general been utilized for the various Service Departments. Thus, the ground floor contains the X-Ray Department, the Laboratories and the Outpatient Department, which extends into the north portion of the east wing, where also is located the Admitting and Discharge Department. This latter has a separate entrance, so outpatient traffic also flows through this way and the same sets of offices, etc., are used for both purposes.

Since the Staff Quarters are in a separate building behind the hospital proper, changing rooms with lockers and toilets were provided in the basement for each category of staff, both male and female. This floor also provides accommodation for the commodious Quartermaster Stores, while the east wing has space for a complete loundry, ice plant, ice storage room, morgue, autopsy room, mail room, barber shop, etc.

The *fourth* and *fifth* floors are mostly typical wards, though the west wing of the fourth floor is given over to a complete surgical Operating Room Suite. Since this suite embodies a few new departures from the standard layout, it is felt that a more detailed description of the salient features may be indicated.

Operating Room Suite

This whole suite is air-conditioned throughout, but is not provided with dehumidification, which was considered unnecessary for the short period of high humidity weather that prevails in Montreal. There are six typical operating rooms with, in addition, cystoscopic and fracture rooms, making eight in all. Each pair of operating rooms has between them a surgeon's scrub-up room and sub-sterilizing room. To serve the cystoscopic and fracture rooms, which are paired together, there is a transformer and control room for x-ray and fluoroscopic equipment common to both. Just off the fracture room is a large "walk in" cupboard for splints, stores, etc., and also a work bench for the use of the orthopadeic surgeon. Where possible the sterilizers, etc., have been recessed. Between the two larger operating rooms is a glassed-in observation room from which either theatre can be viewed. Each room is provided with a dirty linen pass opening into a dirty linen room which can be cleared from the main corridor at stated times.

The floors of all operating rooms are terrazzo, brass stripped and grounded in 8-inch squares—another precaution in addition to the complete air-conditioning against the build up of static electricity. As a further measure in this respect all electrical switches are of the mercury contact type, thus avoiding "flashing". The walls are covered with terrazzo blocks in 33-inch squares which run up to a height of 8 feet, the plaster being brought flush with the top of the blocks. The colour scheme for this suite, as well as for the hospital as a whole, is sea-foam green on the walls with ivory ceilings, where dadoes appear, as in corridors, they are of a darker green.

Lighting for the main operating room is supplied by shadowless ceiling suspended fully adjusted lamps, while general illumination is provided by Holophane recessed lighting fixtures. For depth illumination stand lamps and therapeutic equipment, etc., double utility outlets are located well above floor level, to prevent damage by water when floors are being washed.

The autoclaves in the main sterilizing room are recessed and built in and are of sufficient number that all sterilizing requirements for the whole hospital can be done here. Surgical instruments for the entire suite are kept in glass cabinets which form a wall betwen the main sterilizing room and the corridor, so access to the cabinets can be had from either.

One other space to which it is worth drawing special attention is that allocated to Physi-, Hydro- and Occupational Therapy. This occupies the east wing of the top floor. In addition to the gymnasia, etc., there are a number of workrooms for Occupational Therapy, suitably equipped. The rest of the floor houses the officers' wards. At one end of the wing is a tar and gravel roof, a considerable part of which has been

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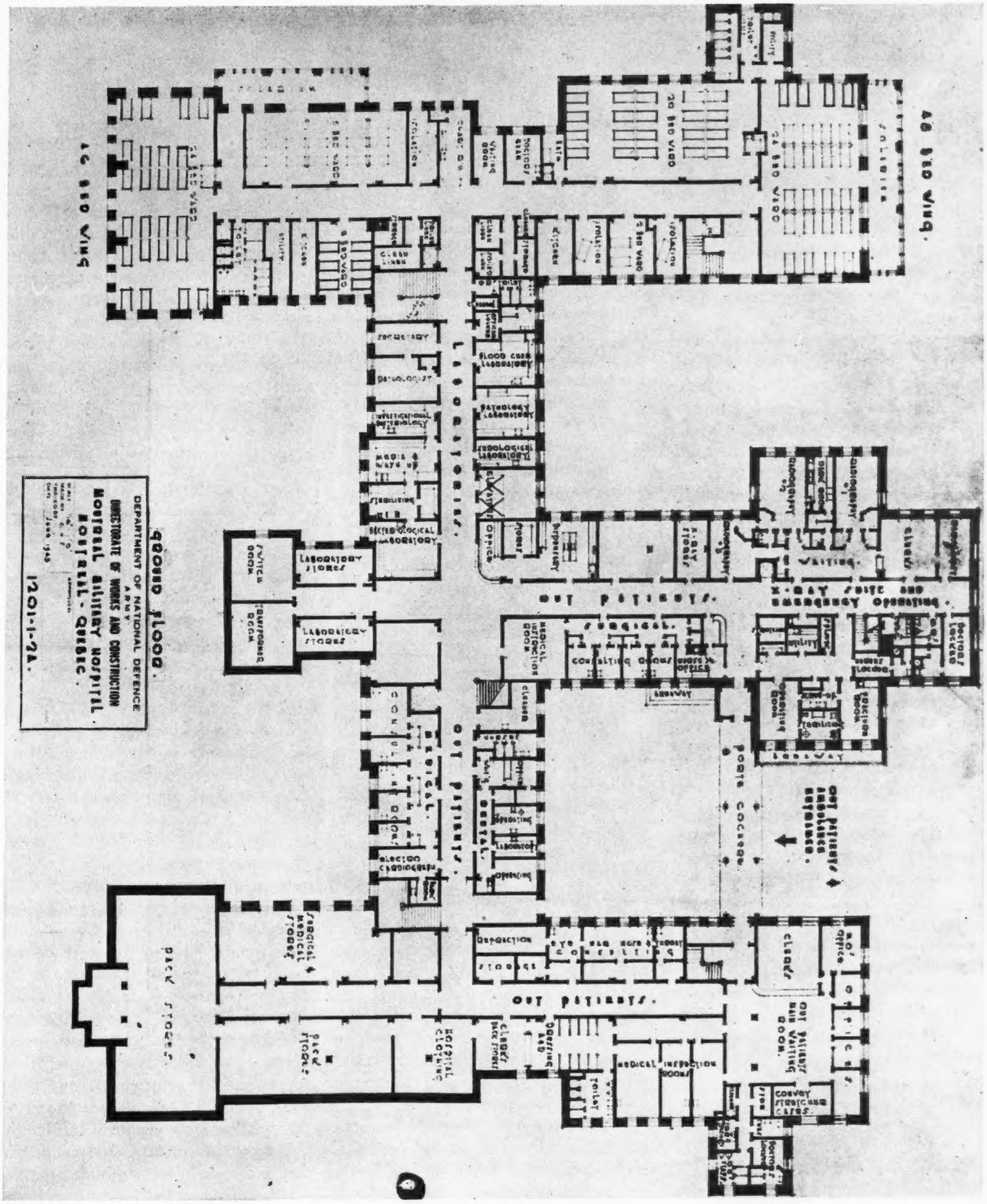


Ground Floor
Montreal Military Hospital

The Chicago Institute for Administrators
—*A Worthwhile Experience*

By DONALD M. COX,
Secretary and Manager,
Winnipeg Municipal Hospitals

ONE of the primary purposes of the American College of Hospital Administrators is to establish standards of competence for hospital administrators and encourage them to meet these standards. Due to the fact that formal educational bodies have not as yet provided sufficient facilities for training hospital administrators it has been necessary for the College to set up its own training programme. Institutes are conducted each year in different parts of the continent. The most complete and comprehensive of these is the annual two-week Chicago Institute. The 1945 session was held at International House on the University of Chicago campus in September. The Institute itself was international in character, as the 116 members in attendance came from thirty-three states, three countries of South America, Mexico, and three provinces of Canada.

More than half of those in attendance were not enrolled in the College, although a considerable number of them planned to seek membership and looked to the Institute to assist them to meet admission requirements. The hospitals represented were a typical cross-section of the hospital field, both as to size and type of hospital. General hospitals were in the majority but there were also sanatoria, mental, communicable disease and military hospitals. The following is a comparison of the bed capacities of the various hospitals represented:

Under 50 beds	6%
51 to 100 beds	27%
101 to 150 beds	13%
151 to 200 beds	14%
Over 200 beds	40%

The Institute was directed by Dr. Malcolm T. MacEachren, Associate Director of the American College of Surgeons; assisted by Mr. Dean Conley, Executive Secretary of the American College of Hospital Administrators. The faculty of the Institute was composed of outstanding people in business, university and hospital circles. The programme consisted of an intensive schedule of lectures, round table conferences, group discussions, personal consultations, and field trips to leading hospitals and to the national headquarters of the American Hospital Association, the American College of Hospital Administrators and the American College of Surgeons. Each lecture closed with questions and discussions.

The main lecture topics, several of which were extended to a series, consisted of:

Administration and management
Professional administration
Business administration
Planning and construction
Physical plant maintenance
Volunteer services
Public relations
Hospital in social progress
Hospital as a health centre
Care of the chronically ill
Legal aspects of administration
Political aspects of administration
The post-war hospital
Small hospital problems
Educational functions
Medical records
Personnel management
Inclusive rates

The round table conferences were headed by outstanding hospital administrators, assisted by panels of experts on the problems under discussion. The hospital visits were so arranged that each individual could select the hospital whose programme best suited his needs.

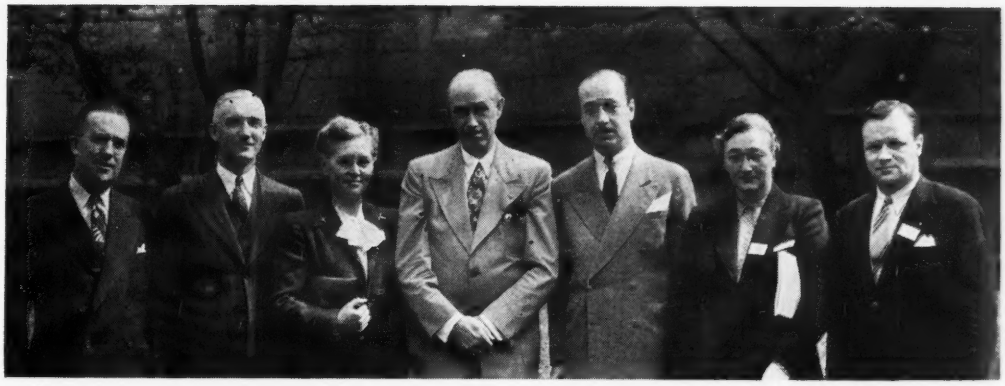
One of the most valuable features of such an institute is the opportunity it affords for informal discussion of mutual problems. International House provided all the space required for the institute, including residential facilities, dining-rooms and conference hall. As a result, those in attendance had ample opportunity to exchange views and it was not unusual to find representatives from Texas, the New England states, the middle west, and Canada, engaged in earnest consultation over the dinner table or in a corner of the lounge room. In the same manner, hospital reports and publications were examined, building programmes discussed, and helpful and constructive suggestions made. These informal gatherings enabled the hospital administrator to become intimately acquainted with alert and capable administrators from all parts of the continent to whom he may, without hesitation, refer for information or advice.

No description of the Institute would be complete without mention of the kindness and hospitality extended to those in attendance. Dr. Malcolm T. McEachern, Director of the Institute, and Mr. Dean Conley, Executive Secretary, worked early and late and were constantly on the alert to assist the members to get the greatest possible benefit.

Right at the beginning the Chicago area A.C.H.A. members and fellows held an informal reception at which strangers were introduced to hospital authorities and fellow members. On two evenings Alexian Brothers' Hospital and Wesley Memorial Hospital entertained the entire group of students to dinner and arranged special programmes and discussions for their benefit.

Through the generosity of WGN radio station the members of the Institute were guests at the Saturday evening broadcast of the Chicago Theatre of the Air. The Museum of Science and Industry provided guides for a Sunday afternoon tour of the Museum with particular emphasis on the medical and surgical exhibits.

Due to our more sparsely settled country, Canadian hospital administrators have only a limited opportunity to meet professionally. For that reason alone they would do well to consider very seriously the possibility of attending the next Institute of the College, or sending their administrative assistants.



At the 1945 Chicago Institute for Administrators

Left to right: Mr. Dean Conley, executive secretary, American College of Hospital Administrators; Mr. Donald M. Cox, manager, Winnipeg Municipal Hospitals; Miss Eugenie M. Stuart, Reg.N., superintendent, Oshawa General Hospital; Dr. M. T. MacEachern, F.A.C.H.A., general co-ordinator; Mr. H. C. Allnutt, administrative superintendent, The Woman's General Hospital, Westmount, Que.; Miss Rahno M. Beamish, Reg.N., superintendent, Sarnia General Hospital; Mr. Walter Hatch, manager, Homoeopathic Hospital, Montreal.

Present-Day Hospital Thinking

—*as noted at the Chicago Institute*

By H. C. ALLNUTT, Montreal,
Administrative Superintendent, The Women's General Hospital

THE 13th Chicago Institute programme showed careful and intelligent planning and was well co-ordinated, despite the diverse nature of the material presented, which ranged from the adequate maintenance of pathological service to fund-raising. Some fifty-odd lectures were given; there were several round table conferences and four hospitals presented demonstrations covering various phases of hospital activities.

There is not a shadow of doubt that sooner or later a better, a more complete service will be expected of hospitals, since there has beeen a steadily growing interest in hospital work on the part of the public and the state. This is one of the results of direct educational campaigns by such groups as the Blue Cross and indirectly by the enormous number of voluntary workers that sprang into existence during the war; it is significant to note that any progress in diagnostic and therapeutic medicine is now news, however, accurately or inaccurately reported by the press.

This is a trend to be welcomed and hospitals can encourage it without turning Mr. John Doe into a half-baked medical man unaware of his ignorance. The layman cannot hope, and should not expect, to acquire a complete knowledge of a science whose practitioners have spent many years of study to master.

The danger of state control seems more imminent in the States than in Canada, but it would appear to be inevitable that certain provincial and federal standards will be set and licensing laws probably made more rigid.

The Postwar Hospital

Smith[1] presented a paper entitled "A Preview of the Postwar Hospital in Fulfilling its Responsibility to the Community".

There will be no basic change in a voluntary hospital's function so far as the treatment of the in-patient is concerned. It will continue to be a "co-operative enterprise" in which good medical care is given to the sick; fundamentally this means a room, a doctor, nursing service, equipment, technical help and nothing more. The change, however, will be in the *quality* of these five requirements. One of the most significant is due to the increasing reliance of the medical profession on diagnostic facilities. The clinical and pathological laboratories were specifically mentioned[2] and Smith referred to them as the "spark plugs" of the medical staff. He went on to say it was better to work on the assumption that as many tests as possible, not as few, should be made despite possible abuses by the staff.

The improvement, however, should be general. There has been a definite upswing in the quality of educational standards both for nurses[3] and for interns[4]. It will no longer be acceptable to have a nurse in charge of a department, such as the case room, who has not had post-graduate training in that particular field. In order

to attract students, a thorough educational programme must be offered. It was suggested[5], that there should be two levels of nursing care, that given by the highly-trained registered nurses and that by the "practical" nurse, who would receive a diploma after a year's training and work in the hospital under careful supervision. More responsibility should be given the former, and intravenous therapy was mentioned as one of the duties she could perform. Incidentally, Dr. R. F. Brown[6] cited an instance where a graduate nurse and three nurses' aides cared for twenty-six patients and, as he expressed it, "did a damned good job".

Functions of Hospitals

The question of a hospital's "proper function" now arises. Obviously it is a place for the treatment of the acutely ill; but what of the chronic patient and the individual who, by the practice of preventive medicine, can be saved unnecessary hospitalization? So far as the former is concerned, the trend in the States is away from the specialized hospital and at least one institution[7] has already set up a small unit to take care of this type of patient. In most of the better-known Montreal general hospitals it has been the practice to cater to the acutely ill, and the chronic patient, when admitted, has usually ben discharged as soon as possible. In 1940 an excellent report was published covering this question[8]. This Montreal committee recommended the building of a hospital exclusively for the care of the chronically ill, a conclusion directly contrary to that reached in the States. There is undoubtedly, however, a certain amount of validity in the claims of those who consider this an extravagant and wasteful solution since, without very careful planning, there is bound to be a duplication of personnel and equipment. Miss Nicholson[9] feels that too great a distinction is drawn between the acute and the chronic.

Community Health

Graham L. Davis quoted Dr. Herrick, President of the New York Academy of Medicine, as saying that hospitals must assume greater responsibility for the health of the community, and Dr. C. F. Wilinsky declared that the public health problems of the future are going to be solved only as a result of the vision and interest of hospital administrative bodies. "Public health is purchasable" and, within certain limits, a community may determine its own death rate.

Hospitals must develop as rapidly as possible as health centres. It was suggested there should be a closer relationship between hospitals and health departments, and both should co-operate to further health education. It would do no harm to establish a more friendly relationship, and integration with a local board would prevent a great deal of duplication. Nutritional clinics might be established. One hospital installed a photo-roentgen apparatus at a cost of $12,000 and chest x-rays were taken of 33,000 in- and outpatients, free of charge. The cost to the hospital, exclusive of diagnosis, was 10 cents per film. Of the 33,000, one and a half per cent showed evidence of active pulmonary tuberculosis and ten per cent showed chest involvement; only five per cent knew of the condition.

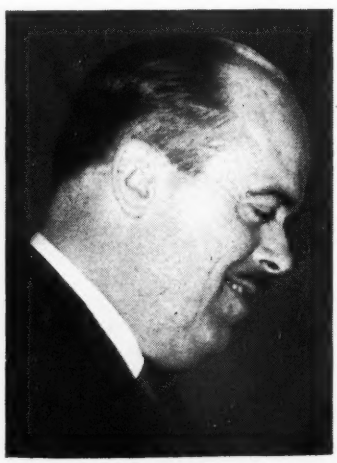
Finance

It is self-evident that if this improvement or expansion in hospital services is undertaken, it will cost a great deal of money. Increased rates seem inevitable and this will necessitate not only public education, but also the education of state boards. The part hospital Councils should play in working out equitable rates is extremely important, since regional conditions are a major determining factor. A standardized accounting system will also be one of the basic needs. The writer does not favour interference by the Federal or provincial governments on the question of rates and operational costs: it is a problem which should be worked out by the hospitals themselves. A natural economic selection will oblige the non-co-operative institution to fall in line and if any hospital's rates are not justified by the services it has to offer, the public will discover this inequality before very long.

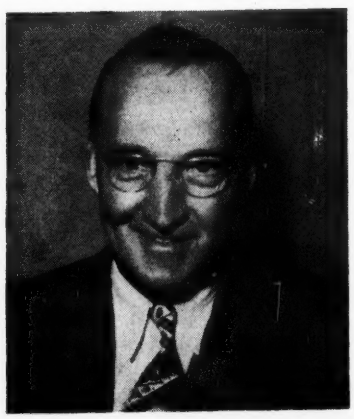
It would appear that if the voluntary hospital is to escape eventual bankruptcy rates will have to approximate a cost basis[11]. In this event, providing everything else is equal, the hospital with a disproportionately

(Continued on page 78)

A.H.A. President Takes Office



Dr. D. C. Smeltzer



Dr. Peter D. Ward

Dr. Peter Ward, superintendent of the Charles Miller Hospital at St. Paul, Minn., was elected president of the American Hospital Association at the meeting of the House of Delegates in Chicago in November, suceeding Dr. Donald C. Smeltzer of the Germantown Dispensary and Hospital of Philadelphia. Owing to war conditions the convention was cancelled this year for the first time in the history of the Association, the necessary business being conducted by the House of Delegates.

We take considerable pride in noting that both Dr. Smeltzer and Dr. Ward are graduates of McGill Unversity and received their training in hospital administration under Dr. A. K. Haywood at the Montreal General Hospital.

S. N. Wynn Honoured by Yorkton Colleagues

LEADERS in the newspaper, political and business life of the prairies paid tribute to S. N. N. Wynn in November when the Yorkton and District Board of Trade sponsored a dinner in his honour to mark the completion of 40 years as editor and publisher of the *Yorkton Enterprise*. From the tributes paid it is obvious that Mr. Wynn has had many interests in addition to his enthusiasm for the Yorkton Hospital and the Saskatchewan Hospital Association.

President of the Board A. A. May presided and the toast to Mr. Wynn was proposed by General Alex Ross, C.M.G., D.S.O., V.D. Coming to Yorkton as a very young man he developed with the young community and proved that the world still has a place for men who are prepared to work hard and depend upon their own efforts. Reference was made to his service to the Board of Trade, to the Rotary Club and his present task as watchdog of the civic treasury. "By these activities he has proved himself a good citizen, and good citizenship is the secret of success in democracy. We talk a great deal about the advantages of democracy, but too often forget that there can be no true democracy unless every citizen is prepared to give of his time and talents in public service."

On behalf of the Board of Trade a fine painting of Bow Lake by the noted painter W. J. Philp was presented to Mr. Wynn.

Other speakers included Mayor Peaker, A. C. Stewart, Galen Craik, Rupert Ramsay, Cameron McIntosh, Judge Smith and others. Speakers and guests came from far and wide and represented the provincial government, various prairie cities, political parties, the judiciary, the Canadian Weekly Newspaper Association, the dailies, the C.P.R., the R.C.A.F. and other groups.

Above: "For He's a Jolly Good Fellow."

Right: Mr. Wynn (on left) receiving the gift picture.

The "Wynning" Way

THE practice of magic or sleight-of-hand may not be an essential attribute for a hospital association president, but to pull a hospital convention out of a hat is quite a test of legerdemain, and that is just what S. N. Wynn did, assisted by John Smith, the energetic secretary of the Saskatchewan Hospital Association.

Owing to restrictions the planned annual convention was cancelled, and all bets were off till 1946; but at the last moment, restrictions were lifted and Wynn and his cohorts jumped the starting gun, took off their coats and got to work. Without wailing or weeping over various overlapping conventions in the larger provincial centres, Mr. Wynn decided to hold the convention right in his own city of Yorkton, and rang the action gong.

We took the train on a cold November day, fully expecting a convention - of - sorts; one of those postponed - but - later - resumed affairs that would be only a ghost of what the original, real McCoy would have been. But did we get a jolt! That convention at Yorkton, Sask., was the most substantial ghost that we have met in a long time; in fact, if Wynn, Smith and Co., could be persuaded to give away their dynamic secret, it would seem that the best way to plan a hospital convention is to do nothing till about two weeks before the set date.

So evidently where "There's a Wynn there's a way".

Scrip. Hosp.

The Subsidiary Worker

on the Hospital Wards

MISS HELEN M. KING, Reg.N.,
Assistant Director of Nursing, Vancouver General Hospital

ALL authorities seem to agree that the outlook for procuring sufficient nurses in hospitals is not going to improve. The demands of industrial nursing and public health services will continually deplete our ranks of qualified nurses who otherwise would have been absorbed into institutional nursing. These posts have many attractions to compete against the hospital position —they are well paid, have reasonable working hours, no week-end work, no night duty, freedom from harassment and exhaustive ward administration, and to a certain extent offer more freedom from the discipline which is necessary in an institution.

The acute shortage of nurses is responsible for the lack of competition for posts which helps to hold nurses in a position; in turn this has brought about marked independence and restlessness of spirit among the younger members. They feel that they are in a position to dictate their own terms. Administrators in hospitals are faced with the problem of maintaining smooth operation of their regime in the face of staff shortage, continual change of staff, and competition from the outside attracting the young nurses whom they have trained and graduated.

The Subsidiary Worker

In the extremity precipitated by the withdrawal of nurses to the Armed Services, hospitals have been forced to turn to the subsidiary worker. They regarded them in the light of a crutch to help them along while temporarily incapacitated. The attitude now is that there is possibly a permanent place for such workers on the staff, as ward aides, or whatever title one wishes to give them. We may regret the step of including the untrained helper into a professional sphere; we may find our standards lowered and that they may replace the highy trained nurse and offer serious competition in years to come. But they do offer a practical solution at the present time. An untrained pair of hands is better than no hands at all. There are many duties on a ward which are time-consuming yet do not require much more than common sense to perform. There is an article in the October issue of *The Canadian Nurse* by Dr. J. C. Meakins, Dean of Medicine at McGill University, supporting the idea of employing less highly qualified people for the less exacting duties in hospitals, leaving the nurse to specialize in the more demanding duties where her education has been prepared to cope with it. In other avenues of work, he says, the specialized individual does not expend energy and time on work which can be comfortably taken over by less qualified people. As he remarks, we must be flexible and adjustable to conditions as they are.

Heavy Casualties

Our experience in the Vancouver General Hospital has been that we must expect a big casualty list among subsidiary workers. Many come but few remain. It appeals very much to many women to work in a hospital, but they have no idea what exhausting work it is, and very soon they resign. Others find the changing of shifts disagreeable, while some resent the discipline; again, because of no advancement in view, they resign for other occupations. In spite of this some of these subsidiary workers have proved reliable, helpful and undoubtedly valuable.

The selection of workers in the untrained group is very important. Older women may be more stable and are more likely to stay, but are slower and tire more easily. Younger women may be more teachable and quicker. The other attributes are what one always requires in those whose duties take them to the bedside—a cheerful disposition, good grooming and poise.

Subsidiary workers are preferably employed on a ward with an all-graduate staff in order to avoid confusion in student nurses' teaching. Subsidiary workers' duties must be controlled and all nurses must clearly understand their limitations. They should be under the sole direction of the nurse in charge, to prevent the imposition on them of work belonging to others, or the confusion of varied and divergent requests from all and sundry. They must be well supervised by someone responsible for that alone, until they have a thorough grasp of the work assigned to them.

Below we weigh the relative advantages and disadvantages of employing subsidiary workers.

Disadvantages

(a) *Economically expensive.*

(i) We estimate one nurse can accomplish the work of a subsidiary worker in half the time. We pay the general staff nurse $119.92 a month and the ward aide $73.43.

(ii) The high rate of resignations means great wastage of time — the time taken in preparing uniforms, the office work entailed, the teaching time wasted.

(b) *Unavoidable Mistakes.*

Mistakes will occur because of ignorance of medical matters. The significance of certain things will be entirely lost—specimens thrown away—food and drink given when it should be withheld, etc.

(c) *Interference with Student Education.*

Certain duties are fundamental in student training and, although routine, must be learned. Simple nursing duties must be learned by juniors.

(d) *Friction in Administration.*

Subsidiary workers may, after some months of service. be temped to overstep their bounds of usefulness and take over duties for which they

Presented at the Instructional Course preceding the annual convention of the British Columbia Hospitals Association in November.

are not suited. Dissatisfaction may result because of their limited scope. They may resent direction from a nurse younger than themselves. On the part of the nurses there may be feelings of resentment against the intrusion of untrained help into a professional field.

Advantages

(a) The subsidiary worker can relieve the qualified nurse of all minor routine work which is time-consuming and leave her free to care for the acutely ill.

(b) She can take over the care of convalescents, where no particular nursing skill is required.

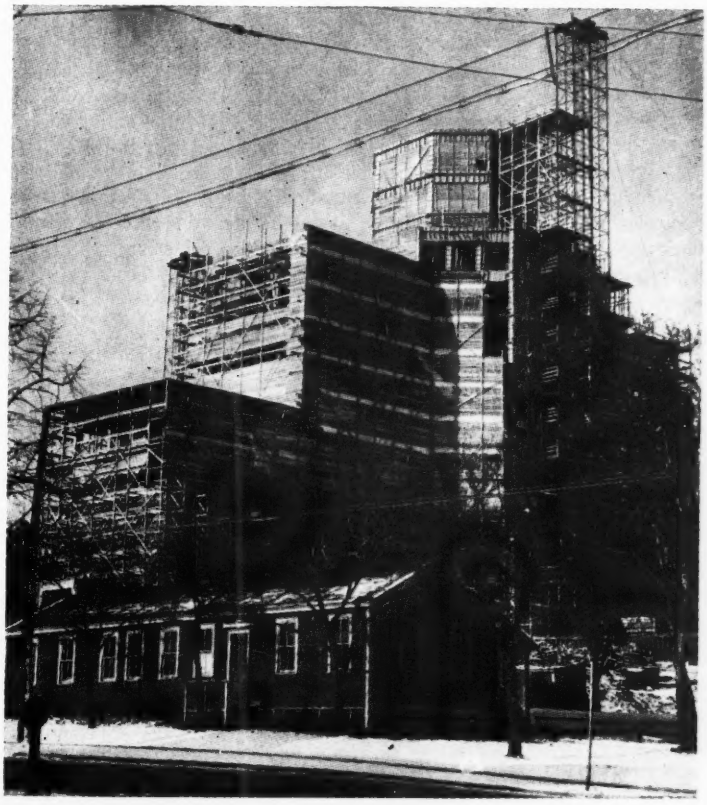
(c) Patients like the subsidiary worker; carrying no responsibilities, she has more time for doing small errands and services.

(d) She can relieve students of non-essential work which does not contribute to their education.

The introduction of unqualified people into hospitals is a new idea and its practicability has yet to be proved by the trial and error method. We are in the trial stages now and will learn where the errors lie. However, head nurses are asking for ward aides on their wards, which shows they are of distinct value.

Control

The next step is the controlling and licensing of these workers in order to safeguard the public. These workers can leave the hospital to go out as practical nurses in the home and as such can be useful to the community, but who is to know what knowledge they have, or what remuneration they will demand? The nursing profession should insist that all "who nurse for hire" should be at a certain standard of proficiency and should be legally controlled.



The Victoria General at Halifax

The above picture, taken on December 13th, shows how work is progressing on the new 400-bed Victoria General Hospital at Halifax, for which the cornerstone was laid on September 5th by the retiring Provincial Premier, the Hon. A. Stirling. The 15-storey concrete and brick building, which will replace the present Victoria General, is expected to be completed by the late fall of 1946. Clinics in the new hospital, staffed by specialists, will do away with the need for Nova Scotians to go to other parts of Canada or the United States for specialized medical and surgical care.

(Photograph by W. R. Carty)

Dr. C. M. Bethune To Direct Hospital

Dr. Clarence M. Bethune of Baddeck, N.S., has been appointed superintendent of Victoria General Hospital at Halifax. He succeeds Dr. George A. MacIntosh.

For many years a resident of Halifax and formerly on the staff of the hospital, Dr. Bethune returned to the city in September after four years overseas.

Dr. Bethune took over his position as hospital superintndent on December 1.

Bill to Legalize Lotteries to Come Before Parliament

Sweepstakes may become legal in Canada if the proposal to amend the criminal code is approved by parliament, says the *United Church Observer*. It calls attention to the fact that the Hon. Ernest Bertrand, as a private member, twice introduced a bill to legalize sweepstakes, and twice met defeat. "Ernest Bertrand is now the postmaster - general of Canada," it adds.

"A proposal to give discretionary powers to attorneys-general in the matter of prosecution concerning lotteries is being considered by the Dominion cabinet. If the criminal code is amended to grant these powers there is nothing to prevent the attorney-general of a province making sweepstakes legal. The result would be that the whole of Canada and the U. S. would be flooded with lottery tickets originating in that province, just as they were flooded with Irish sweepstake tickets originating in the Irish Free State before the war."

Obiter Dicta

Should "Know-How" be Required of Trustees?

"THERE is no friendship between those associated in power; he who rules will always be impatient of an associate."—Lucan.

Much has been said of the value of "know-how". "Know-how" has been an important factor in the talks about the atomic bomb.

Recently a hospital board in an average Canadian city decided to make certain changes in the accounting practices of that institution. Between certain members of the hospital board and a chartered accountant, retained as consultant, it was decided to strip the superintendent of a great deal of authority and appoint a business manager and a credit manager to carry on the affairs of the hospital, each of whom would be responsible *directly* to the Board of Trustees or the Finance Committee—thus laying three separate lines of direct communication and authority from three separate officials directly to the Board. The business manager would be empowered to "check" the superintendent, and the superintendent, the business manager!

The hospital trustees and the chartered accountant meticulously adhered to recommended accounting practices of the Dominion Bureau of Statistics and other standard authorities, and then destroyed their work by attempted to set up administrative practices contrary to accepted and approved procedures. All of this was done without consulting the administrator or other available authorities on administrative "flow-sheets".

It has long been recognized in the hospital field, as well as elsewhere, that there must be one central administrative authority. There can be only one captain to a ship, and the owners give him full authority to operate that ship. It is the recognized practice in hospital administration to channel contacts between departments and the Board through the administrator; any other practice leads only to confusion and lack of harmony.

This situation drives home a forceful point—should there be a standard of knowledge and appreciation of accepted hospital practices established for the responsible office of trustee on the Board of a public hospital? Should trustees be required to possess the necessary "KNOW-HOW" to ensure that the best administrative methods are supported and established by persons or groups honoured by trusteeship? We believe that the voluntary hospital system would be strengthened by such a requirement and that a hospital trustee should possess the requisite "KNOW-HOW".—R.C.W.

This Chisholm Controversy

WE had intended to stay out of this hue and cry over the Washington address of Major-General Brock Chisholm, preferring to enjoy the floundering of outraged editors, politicians, pulpiteers and Santa-Clausers as they got beyond their depth in attacking the psychiatric logic revealed but in part by an all-too-brief press excerpt from an address written for a selected group of specialists in a little-understood field. Now, however, that this intriguing little debate about whether it is as bad to be good as to be bad has got to the point where people who have probably never read the full text of the Washington address on "The Responsibility of Psychiatry for Peace" are demanding Doctor Chisholm's resignation as Deputy Minister of National Health, we think that it is high time to live up to our Irish ancestry.

It is not our intention to attempt to shed any light on this question of moral maturity, or on the relationship of childhood beliefs and peptic ulcers, even though we have a feeling that we could write at least as soundly, or interpret Dr. Chisholm's statements as well, as most who have taken burning pen in hand. We realize full well that, like most people trying to score a point, the doctor may have over-stated his ideas for emphasis. Being a psychologist he appreciates the cardinal necessity of stimulating his audience. But it is our intention to protest strongly this ridiculous demand that Doctor Chisholm be dismissed because he interpreted a few unorthodox observations into one of the most thought-provoking addresses we have read in a long time—one that will be a classic long after its critics are forgotten.

From coast to coast there is intense satisfaction among the medical profession, the nurses, hospital people, welfare workers and all who are concerned with the health of the people that the important post of deputy Minister of National Health is held by a physician with such high qualifications and such conscientious zeal for the tasks in hand. To those of us who have known him over the

years and have worked with him, his stature has grown with each passing year.

Major-General Chisholm climaxed a commendable military career by the brilliant leadership which he gave the Army Medical Service as its Director-General. Psychiatry and psychology have come into their own in this war and the methods for early detection of psychotic imbalance developed by Major-General Chisholm and his colleagues, with the resultant marked reduction of shell-shock, battle fatigue and mental breakdown in general, have saved this country untold sums of money alone, not to mention the averted suffering of potential victims and their families. Doctor Chisholm has introduced a new approach to our national health problems and it would be a major loss if he were forced to leave public service, as might well happen, because of the attacks of those who do not understand his point of view or cannot agree with all that he said. We agree that a public servant must be more careful of his utterances than is necessary in private life and he should refrain from embarrassing his Department, but that is not the main issue. Have we come to this in Canada that even a great leader in our national fight for freedom is himself to be denied the right to freedom of speech?

Vancouver Drinking Water

IT would appear that not all of the health cranks have moved to California; at least Vancouver would still seem to have a fair share of them. In this modern era when intelligent people everywhere are alive to the vital importance of having, at any cost, a safe water supply, Vancouver citizens have actually been asked to vote on whether they want their water chlorinated or raw! Two years ago when chlorination was initiated there was a tremendous rumpus and "irate citizens" with more time and paper than judgment wrote endless letters to the press. This fall they re-argued it all over again. The Mayor of North Vancouver castigated the medical profession for its stand in favour of chlorination. In forty years' residence he had never heard of complaints against raw water; we presume he carries fire insurance and life insurance although he may never have experienced fire or death. The head of the Victoria Anti-Chlorination League solemnly declared that this is the first step towards dictatorship. It would be interesting to know what inter-locking membership there is in anti-chlorination leagues, anti-vaccination societies, anti-vivisection and anti-pasteurization associations and such-like anti-everything that spells progress.

The facts have been clearly outlined by those who know. Mr. R. Bowering, B.Sc. (C.E.), M.A.Sc., provincial public health engineer, reminded the Metropolitan Health Committee of what happened to Croydon in 1937, when 250,000 citizens went down with intestinal trouble due to a faulty water supply and forty-three died. He pointed out that there is no scientific evidence of chlorination being in any way harmful to human beings. Dr. C. E. Dolman, professor of bacteriology at the University of British Columbia, warned them that their water is not safe. So did spokesmen for the medical profession. Dr. Dolman reminded his audience at one meeting that 230 typhoid carriers had been identified in Greater Vancouver in the past two years and waved aloft a test tube containing 150,000,000,000 cholera organisms.

Actually Vancouver is fortunate in that the water supply is drawn from up in the hills and not from water exposed to sewage contamination upstream. Its water is unusually good—clear, soft, tasteless and odorless. No serious epidemic *up to the present* has been traced to the water supply. But the rapid influx of people to British Columbia is making it more and more probable that something may happen in the not-too-distant future. Mr. Bowering showed that tests on 22 separate days at Capilano Creek, largest single source of supply, revealed at least one contaminated sample on each day. It would appear that much of this agitation, as in the case of several other issues on front pages, is largely political. As one alderman remarked, "There is more politics than chlorine in our water".

A.H.A. to Register Qualified Hospital Architects

THROUGH its Council on Hospital Planning and Plant Operation, Dr. Frank R. Bradley of St. Louis, chairman, the American Hospital Association is now reviewing applications of architects for inclusion on its registry of architects especially qualified for hospital construction. The basis for qualification was drawn up by a committee of hospital administrators and architects and quite a number of architects are now seeking recognition. Hospitals are being encouraged to employ listed architects or, if this is not feasible, to have the unlisted architects associate themselves with one who has has had wide hospital experience and is listed. It is not known whether any of our Canadian architects have requested this recognition.

This action on the part of the Association is in keeping with the widespread practice of setting up standards of evaluation whereby qualification to perform a given service or a certain function can be recognized. To some it may seem arbitrary for a hospital association to publish such a list and, undoubtedly, many architects not included will criticize this action. It may be held that any qualified and registered architect should be listed. The fact remains, however, that all too many hospitals reveal how inexperienced in the intricacies of modern hospital design was the architect employed. Hospital planning is a highly-developed specialty and requires wide knowledge and experience. In addition to being an expert on the basic principles in architecture, the hospital architect must know a great deal about the day-by-day functioning of hospital services, and this knowledge is not easily obtained. Moreover, the present type of building will last for the best part of a century (perhaps unfortunately) and therefore some special insight into the trends for the future in hospital use and planning is most desirable. It may prove quite difficult to be fair to all in this listing and we would not like to be charged with that responsibility, but undoubtedly this registry will be much appreciated by trustees charged with the wise spending of large sums of public or trust funds.

British Columbia Conference Holds Interesting Meeting

By SISTER MARY DOROTHEA, S.S.A.

St. Joseph's Hospital in Victoria was hostess to the Sixth Annual Convention of the Catholic Hospital Conference of British Columbia. Fifteen member hospitals throughout the province sent delegates to the meeting which was, for the convenience of those in distant parts of the province, scheduled to precede the British Columbia Hospitals Association convention.

His Excellency the Most Reverend John C. Cody, Bishop of Victoria, opened the Convention by offering the Holy Sacrifice of the Mass for the success of the work of our Catholic Hospitals. He was assisted by Reverend Father A. J. McGowan, chaplain to the Conference. Addressing the delegates after the Gospel of the Mass, His Excellency developed the text: "The letter killeth but the spirit quickeneth", urging the sisters to consecrate themselves without reserve to the service of Christ in the great work of bringing health to the sick, and in the administration of the hospital in all its varied departments.

Telegrams and messages of encouragement and inspiration were received from many persons vitally interested in the apostolic work undertaken by our various Sisterhoods in the conducting of hospitals.

Of special importance to the meeting were the detailed reports submitted by Sister Gertrude, F.C.S.P., St. Paul's Hospital and Sister Mary Claire, S.S.A., St. Joseph's Hospital, Victoria, giving information concerning the deliberations of the Canadian Hospital Council and the Catholic Hospital Council of Canada during their respective conventions held at Hamilton, Ontario, during September. These two Sisters were delegates to the above-mentioned Councils and through them the British Columbia Conference received official recognition by the Canadian Hospital Council and was accorded a vote in that assembly.

The officers for the coming year are:

President: Sister Columbkille, St. Paul's Hospital, Vancouver.

First Vice-President: Sister Amata, St. Joseph's Hospital, Comox.

Second Vice-President: Sister Ruth, St. Vincent's Hospital, Vancouver.

Secretary-Treasurer: Sister Helen Marie, St. Paul's Hospital, Vancouver.

An Unusual War Memorial

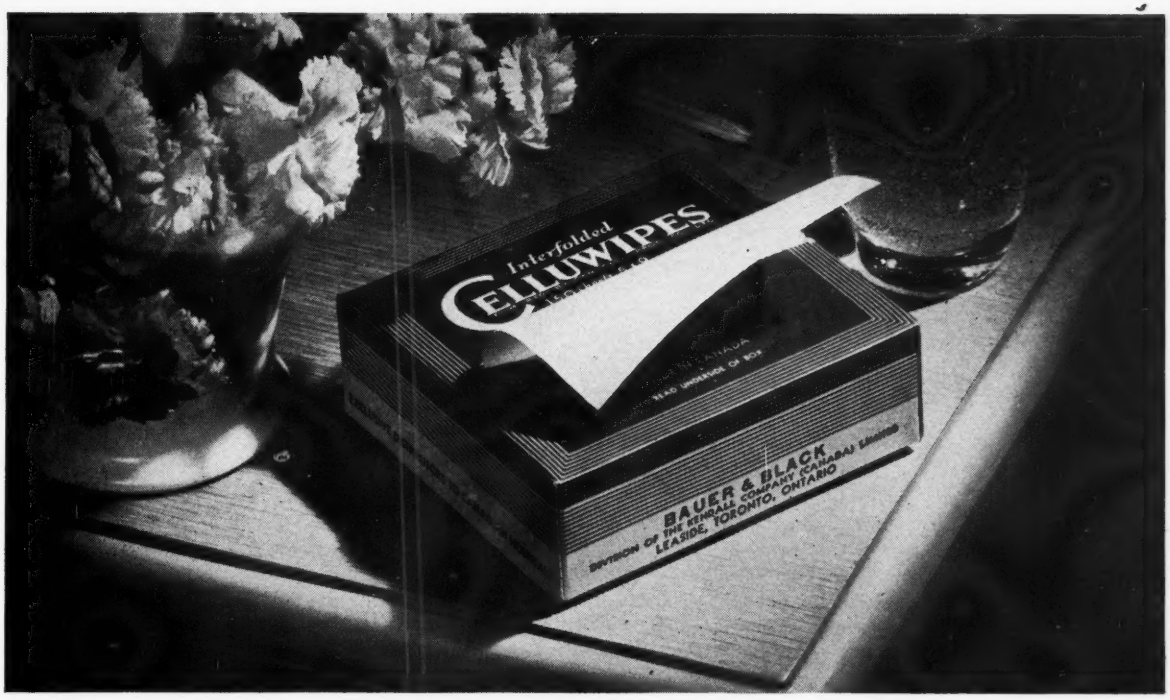
The battle of Alamein, which Field Marshal Montgomery has declared to be the great turning point in the War, is to be commemorated by an extension of the Enham Village Centre in England, to be known as Enham-Alamein. A million dollars has been raised for the purpose, of which nearly half has been given by the people of Egypt. The Enham Village Centre was established during the War of 1914-18 on the lines of the famous Papworth Colony for men suffering from tuberculosis. The new Alamein village will consist of about one hundred houses, a medical unit, hostels and ancillary buildings. It will thus become a symbol of the long-established friendship between Great Britain and Egypt.

Site of the future Enham-Alamein is marked by arrows.

This Is Enthusiasm

Probably a record for distance travelled at the autumn meetings in November was set up by the delegates from the Peace River district to the coast conventions in Vancouver. Sister Superior Teresina, Superior of the Providence Hospital at Fort St. John and Mr. S. H. Tuck, Secretary of the Pouce Coupe Community Hospital, had to make a round-trip air flight of 1,700 miles to take in the meeting. Mr. Tuck was a prime mover in the establishment of the hospital at Pouce Coupe and found the discussions so valuable that he is already planning to fly back next year.

For years British Columbia has had almost every hospital represented, despite geographic and transportation difficulties unequalled anywhere else in Canada. A major factor in this achievement has been the pooling of travelling expenses. Moreover the Association has still further lightened the "average" travelling account by contributing $400 to the pool fund each year from the general funds of the Association. Alberta voted to adopt the pool principle at its last meeting.



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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

The Colonial Office have just issued the report of a committee which was quite unusual, in fact, I believe, unique, in the scope of its terms of reference. In the first place it was appointed to consider "the training of nurses in the United Kingdom and the Dominions for service in colonial territories". The second matter was the training given in the Colonies to indigenous nurses.

The first reference was a recognition that the Dominions might be willing to take part in the considerable undertaking of providing an important contribution to the health services of the Colonies. It involves the welfare of sixty million peoples, without taking into account dependencies and mandated territories. Two-thirds of them live in Tropical Africa and the remainder mostly in the West Indies, Ceylon, Hong Kong and Malaya.

Dealing with the guiding policy to be adopted the Committee recognize that "a primary aim of medical workers in such territories should be to improve health standards and to control the transmission of disease". Moreover the successful application of a preventive policy will depend very largely on the care devoted to the health of mothers and children. This gives scope for the work of women with breadth of outlook based upon a sound general education, which is probably better provided from a training in the Dominions, especially Canada, than it is in this country. The nurse has a contribution to make to the well-being of the whole community and so there has come into use the term "community nurse". The Committee give some description of what they have in mind in using the title.

> "Ideally," they say, "the community nurse would be a nurse who had received in addition to her training in general nursing, such instruction as would fit her to be a leader in a village community; to visit and attend patients in their homes and advise women about their household problems, the hygiene of the home and the care of children and infants; to conduct health propaganda among the village people; to inculcate the better use of local foodstuffs and better cooking methods; to watch over the health of the people in the houses she visits and to advise them about treatment; to visit schools, to inspect school children and to play a part in the work of health education in schools, which is so important a foundation for inspiring the whole community with a new attitude to health matters; to assist at the work in the clinics, particularly the child welfare clinic; and generally to be the exponent of better health for all in the community."

To an increasing extent the Committee foresee that the nursing staffs in the Colonies should be drawn from the local peoples. Accepting this principle there are three ways in which the training might be carried out: (a) the whole of the training might be given in the United Kingdom or in the Dominions. Apart from the cost, which is a substantial item, the Committee consider that there is the serious objection that "the curriculum at present in use in British training schools does not stress the preventive and social aspects of medicine sufficiently for Colonial needs"; (b) training for the nursing certificate might be given in local nurse training schools and nurses might come later to the United Kingdom or elsewhere for post-registration instruction. That would involve that the training in the local nursing school should be raised as soon as possible to a standard comparable to that of the training given in the United Kingdom or the Dominions so as to allow of reciprocal State registration, if desired; (c) Training for the nursing certificate might be given in the local nursing schools and post-registration work might also be taken in local schools. This is clearly the long-term aim. In the meantime there is considerable opportunity for the interest of the Dominions in the undertaking and the enlistment of the enthusiastic assistance of individuals in a valuable piece of work for the welfare of the Colonial peoples.

In many areas, of course, the general standard of education in the Colonies has not yet been reached to provide an adequate foundation for the course of training for the nurses adumbrated in the Committee's report. Nevertheless the Committee are strongly of the opinion that the backwardness of girls' education is not in itself a valid reason for delaying the establishment of a nurse training school. Experience has demonstrated that while the uneducated are poor material to turn into nurses, they can be trained into surprisingly competent nurses provided that the instruction is severely practical and teachers exercise great patience.

It is clear from this line of thought that the greatest demand of all will be for teachers to act in the capacity of Sister Tutors and "that it will have to be met very largely by the recruitment of experienced women

(Concluded on page 84)

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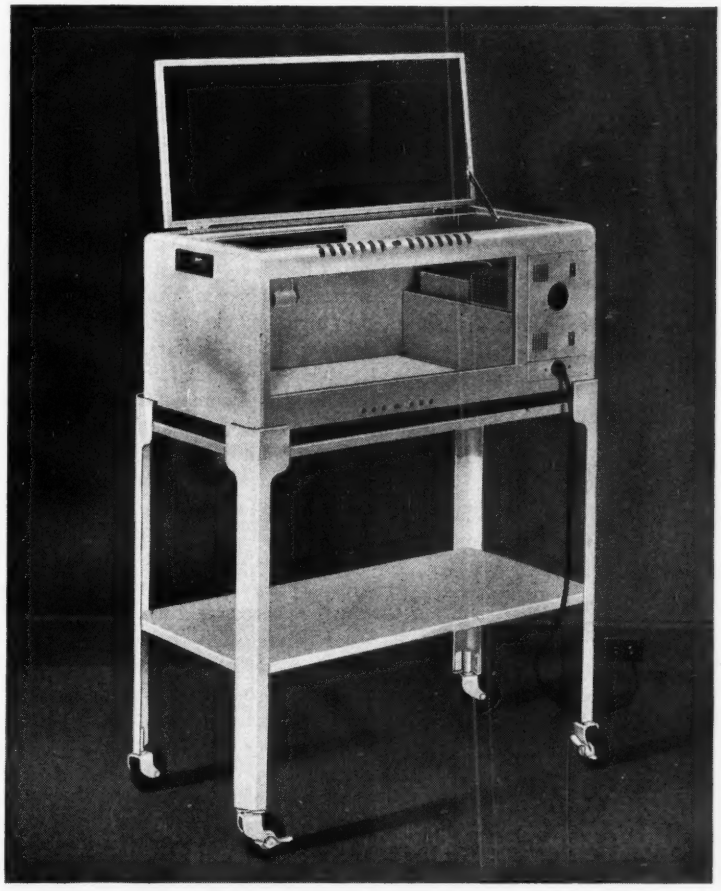

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Here and There

By the Editor

Why Supervisors Die Young

The administrator of one of our large hospitals sends us the following excerpt from a report sent in by the supervisor of the children's floor. We pity the poor mother. To quote:

Peter and Paul, identical twins, four years old, were admitted August 6th at 7.20 p.m. and immediately put into beds that were named, but as we found out the next afternoon they changed beds during the night.

In the morning, August 7th, Paul was in Peter's bed and was sent to the Operating Room as Peter and had his tonsils and adenoids removed.

Peter, who was in Paul's bed, went to the Operating Room as Paul but because of coryza and slight temperature was returned without having a tonsillectomy and adenoidectomy.

In the afternoon the mother visited and said the boy with the coryza was Peter and Paul was the boy who had had the operation. The bed tags were changed immediately.

Yesterday, August 8th, they were out of bed without permission and tore the tie-downs when restrained.

Last night, August 8th, after 7 p.m. Peter was given the usual preoperative check-over by Dr. J. White, patches were noticed on his tonsils so he was evidently in the correct bed.

To-day, August 9th, at noon before sending Peter to the Operating Room we tried to examine his throat, as a check to make certain we had the right child, but he was unco-operative, so we were not successful. When asked their names they did not answer.

At lunch Peter, whom we thought was Paul, had been given some jelly, a little later we found he had given it to his brother. This was reported to the Operating Room as well as the fact that we had trouble telling them apart. When the child was under anaesthetic in the Operating Room it was discovered that he had had his tonsils removed, so his name was not Peter but Paul. Evidently they had changed their beds during the night.

Paul had been discharged August 8th, but at the request of his mother and since we had the cot to spare, he had been left in, mainly because she wished the twins to have company.

(Signed)—
Supervisor of Children's Floor

(In future twins in this hospital must be admitted to private rooms.)

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Not So Long Ago

A few weeks ago we were talking to a nice gray-haired woman who was recalling the days when she was a pupil nurse in one of our largest and most highly reputed schools for nurses in Canada. Its then director has long since become a revered figure in nursing tradition, although it is only some 42 years ago that this friend, then a timid girl of seventeen, went "into training".

Typhoid patients, then very numerous, were treated on the open ward and without special precautions. Screens were a rarity and the ubiquitous fly abounded. It was only a matter of a few months until the young nurse herself went down with typhoid, a not uncommon occurrence in those days. She was put to bed in a female ward where she got very good care indeed. The flies, however, were so troublesome that the nurse in charge conceived the brilliant idea of getting some of those sticky sheets of "tanglefoot" flypaper and spreading them out on her pillow and on the bedspread. They helped.

It so happened, however, that this ward had a cat which was let in each morning at seven, Sundays included. In turn it visited the patients in search of little tidbits. Typhoid precautions, such as there were, meant nothing to Thomas. Coming to our friend's bed, he leapt up as usual, this time landing right in the middle of a fly-studded sheet. Losing his balance he fell upside down onto the next sheet. The more he struggled the more enveloped he became. Finally, the clawing, sputtering mass of paper-encased felinity fell onto the floor where, with one wildly rounded eye to guide it, the poor cat stumbled and rolled to the door. To the best of our friend's recollection, Mr. Thomas was never seen again.

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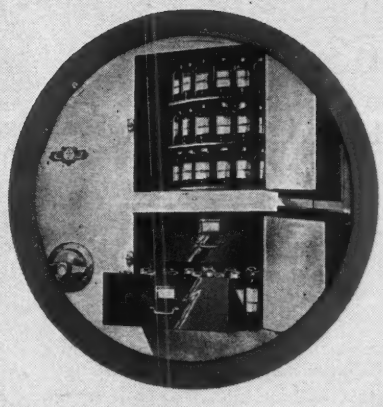
The Spirit of a Pioneer

When Dr. MacNeil of Dauphin was given a life membership in the Manitoba Hospital Association in November, an honour deservedly conferred upon one who has done so much for the sick and the youth of his province, he made one statement in his witty reply which seems to typify more than anything else the spirit of this great Scotsman and, for that matter, could well be guided to the young people on whose behalf he worked so many years.

Recalling the days when he went out on the virgin prairie and broke sod for the sowing, a sod that was so tough that ploughing was a real test of skill, he stated that, unlike some of his neighbors, he deliberately ploughed at right angles to the road allowance "for he was not afraid to let others judge his ability". We like that spirit—doing his best, unashamed, even proud, of the results, and willing to stake his reputation at the bar of public opinion.



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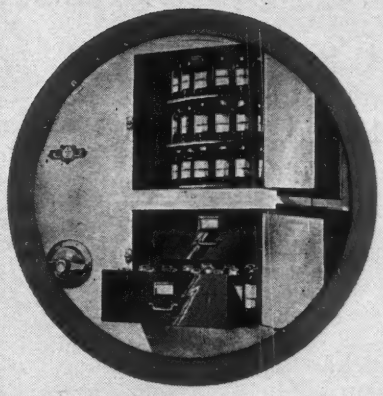

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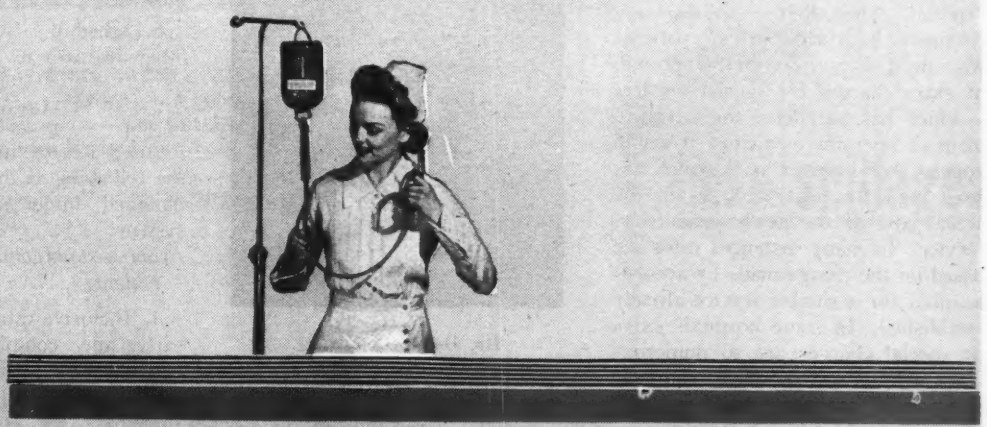


INCLUSIVE RATES for Hospital Charges

A SPECIAL committee on inclusive rates of the American Hospital Association, under the chairmanship of Carl I. Flath of Charlotte, N.C. (formerly of the Wellesley Hospital, Toronto), has submitted an extensive report on this subject to the Association. This committee is a division of the Council on Administrative Practice of which the chairman is Dr. Fraser D. Mooney (McGill '24) of Buffalo. The following is a digest of this report:

Fifty years ago as hospitals emerged from the almshouse stage and began to be used for the care of the sick who were not indigent, their rate structures were of a very simple form. All of the then available services were covered by a single charge, usually stated as a rate per day or week. Then, as scientific procedures including laboratory, x-ray, pharmacy, anaesthesia and other ancilliary services were applied to hospital care, greater investment and higher operating costs resulted; these in turn created a problem of establishing rates to cover the cost of such services. The unit charges established for these innovations were not always in proportion to the cost of the service rendered.

Nowadays, however, procedures which seemed to warrant the term "special" when first established are routinely provided for all patients who need them. But in the growth of extra charges for special services —which has paralleled the advancement of scientific medicine—it would appear that little or no attempt has been made to relate charges to the actual cost of the newly established service. In many instances rates are based on the charge made by another hospital for a similar service already established. In some hospitals extra or special charges are so numerous that the term "nuisance charges" adequately describes many of the assessments levied on patients.

An inclusive rate, sometimes incorrectly referred to as a flat rate, may be defined as a predetermination of the complete charge for complete hospital services in a particular type of accommodation for a given length of stay, without regard to the degree of use or adjunct facilities or services of the hospital—or, an inclusive rate apportions all charges for essential and strictly hospital services and procedures incidental to the care of inpatients on a consistent, uniform basis irrespective of actual utilization: the only fundamental variations thereto arising from length of stay and type of accommodation.

A tentative list of services generally provided under an inclusive rate might include bed and meals, floor duty nursing, formulary drugs, dressings, operating and delivery room service, clinical laboratory service, radiologic service, anaesthesia and gas therapy, blood and serum therapy, occupational therapy, physical therapy, and plasma and blood transfusion service. Excluded would be such things as local and long distance telephone service, beauty and barber shop services, stenographic services, guests' meals, private duty nursing and similar luxury items not directly related to diagnosis and treatment.

Dr. Harry Coppinger

Dr. Harry Coppinger, superintendent of the Winnipeg General Hospital, was elected 3rd VicePresident of the American Hospital Association at the meeting of the House of Delegates at Chicago in November.

Inclusive rates should not be confused with "flat rates" which may be designed to cover many combinations of services, such as nose and throat cases, obstetrical cases, diagnostic services, laboratory studies, etc.

Nor are they "bargain" rates. Actually the over-all income per patient day may be increased. Advance payments or cash discounts are not an essential characteristic although they may be part of the arrangement.

Several types of inclusive rate plans are now in operation:

1. Average the cost of all extras and add to the basic room rate.

2. As above but with a reduction to long-stay patients.

3. A fixed surcharge on the room base rate for laboratory services and drugs but with a variable charge for certain surgical procedures.

4. Fixed room base rate with the surcharge spread over a period of days varying according to the type of professional service. For example, a higher surcharge for surgery and obstetrics than for medical ward care.

5. Surcharges are graded day by day according to the average use made of these facilities calculated by days of stay. (It may be found that 60 per cent of all extras are rendered on the first day, 15 per cent on the second, etc.).

6. Schedule adjusted to fit in with other features or arrangements.

Advantages

Advocates of inclusive rates offer the following as the advantages to be obtained under an inclusive rate system:

From a standpoint of physician and patient:

1. Inclusive rates make possible an early and complete understanding between the patient, physician and the hospital on the matter of charges for care.

2. When the above is possible,

physicians should find it easier to arrange for the admission to hospitals since the cost can be largely predetermined.

3. The inclusive rate method of levying hospital charges should result in improved patient-doctor relationship, improved patient-hospital relationship and improved hospital-doctor relationship.

4. Inclusive rates remove certain friction between physician and patient over a long list of annoying minor charges.

5. Inclusive rates encourage a thorough diagnosis.

6. Patients are not denied necessary services because of their own or the physician's desire to keep the bill down.

7. The physician does not have to deny himself a modest fee in order to obtain additional diagnostic or therapeutic service for his patient.

8. Inclusive rates make it possible for the physicians to discuss the net cost of hospitalization at the time it is recommended.

From the standpoint of the hospital:

9. The time-consuming operation of making out charge memoranda for countless small items, such as a mild sedative or a few ounces of rubbing alcohol, is saved for today's already overworked nurses.

10. The ability of the physician, patient and hospital accurately to determine hospital charges for the patient—in advance—from a publicized schedule, makes it possible for the patient to plan to meet the expense beforehand; or if credit arrangements are necessary, these can be specifically set up at the time of admission on the basis of a known amount of money, thereby reducing collection problems.

11. Bookkeeping is somewhat simplified.

12. An inclusive rate plan facilitates the matter of adjusting rates to cost, with high degree of accuracy.

13. Complaints which invariably centre on "extras" are eliminated.

14. The hospital has only one thing to sell and that is complete hospital care, not a series of unrelated personal and professional services.

Objections Raised

1. The most frequently raised objection has been in regard to increased usage or abuse of such special services as laboratory, x-ray, pharmacy, etc.

2. It is not possible to measure the financial effect of work done by the various special service departments of the hospital, since a record of earnings by service units is not available.

3. The cost of operating departments such as x-ray, laboratories and physiotherapy will be increased as departmental volume increases. This is only true of the fluctuating items of labour and supplies.

4. It is claimed that an inclusive rate plan discourages the providing of new equipment or facilities to meet current discoveries in diagnosis and treatment.

5. The inclusive rate plan interferes with the contract arrangements which roentgenologists, anaesthetists and other specialists work under, whereby remuneration to these individuals is based on fees collected.

6. Patients object to paying for "someone else's bill", preferring to pay only for services they actually receive. Some insist on a complete breakdown of the account.

7. Most commercial insurance companies and certain Blue Cross plans operate under a basis of reimbursement requiring detailed charges for room and board and extra services.

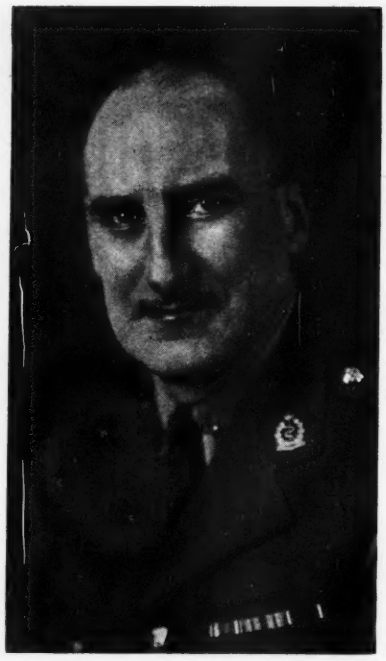
8. It has been stated that calculations established on average patient experience under day-rate-plus-extras is not a safe base on which to build an inclusive rate schedule for the reason that the former offers certain deterrents to over-use of special services and there is unrestricted use under the latter; therefore, conditions are not comparable. Further, it is stated that admissions of various types of cases under the inclusive rate plan would not necessarily follow the experience of any sample group studied for purposes of establishing the rate.

(These objections are commented upon and discounted to a large extent in the Report).

Establishing An Inclusive Rate Plan

In setting up any system of hospital charges an attempt is made to establish a total revenue figure which approximates total cost. In establishing an inclusive rate, calculations will be based on the total return expected or required to meet the total cost of providing full service. Emphasis will be on past experience and the final rate will be largely dictated thereby—adjusted to meet changes which good judgment may anticipate for the reasonably immediate future.

Two methods of ascertaining inclusive rates are outlined in the Report. One is developed by analysis of the total operating picture for a given period (one year) and the other by analysis of a large sample of typical patients' ledger accounts.



Col. Mackenzie to Practise as Hospital Consultant

Colonel John C. Mackenzie, formerly general superintendent of the Montreal General Hospital and for several years actively engaged in hospital work in the Canadian Army overseas and in Canada, has resigned his civilian post from which he has been absent on a leave-of-absence and will devote himself to consultative work on hospital construction and related problems. Doctor Mackenzie's wide experience in civilian hospital management and construction and his intimate connection with the programme of hospital expansion in the services have fitted him exceedingly well for his new undertaking. We understand that Doctor Mackenzie is leaving headquarters at Ottawa in the immediate future and will establish offices in Montreal.

In operating theatre or hospital ward

Heat Comfort Always
WITH

DUNHAM DIFFERENTIAL HEATING

UNDER *All* OUTSIDE TEMPERATURE CONDITIONS

Here are some of the prominent Canadian Buildings in which Dunham Differential Heating is providing true heating comfort —along with date of installations:

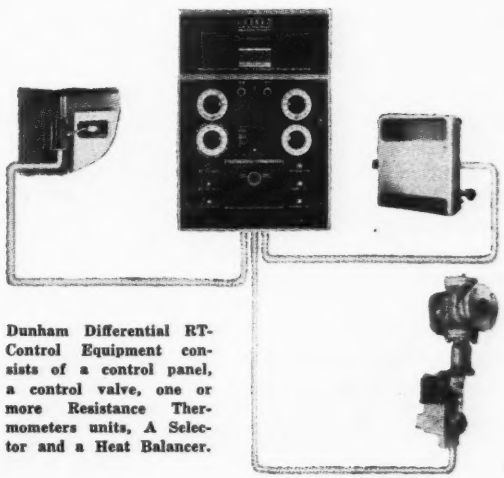
Hotel Dieu de St.-Joseph, Campbellton, N.B.	1939
St. Joseph's Hospital, Lachine, Quebec	1939
Victoria Hospital, London, Ontario	1939
Hospital de l'Enfant Jesus, Quebec, P.Q.	1936-1937
Western Hospital Addition, Toronto, Ontario	1934
Toronto Hospital for Consumptives, Weston, Ont.	1937
Sanatorium St.-Georges, Mont Joli, Quebec	1938
Port Arthur Hospital, Port Arthur, Ont.	1929-1938
Hospital Ste.-Anne Chapel, Quebec, P.Q.	1937
Hotel Dieu St.-Michel, Roberval, Quebec	1941-1942
Hospice de Baie St. Paul, Baie St. Paul, Que.	1939
St.-Jean de Dieu, Montreal, Quebec	1934-1935-1936

With Dunham Differential Heating, heat is maintained in all parts of a building — at comfort levels. This is accomplished by controlling the supply of heat primarily by the rate of heat loss from the building construction and not wholly by either inside or outside thermostats.

The resistance thermometer type control equipment used with the Differential System, overcomes the difficulties in locating inside thermostats and the possibility of heat lag if outside temperature alone controls the heat supply.

In operating theatre or hospital ward, in gym or classroom — in whatever type of building requires different temperatures in different parts of the building, Dunham Differential Heating offers definite advantages.

If you would like to secure full information on Dunham Differential Heating for installation in new buildings or for changeover of existing heating plant, consult with your nearest Dunham office. C. A. Dunham Company Limited, 1523 Davenport Road, Toronto 4. Offices from coast to coast.



Dunham Differential RT-Control Equipment consists of a control panel, a control valve, one or more Resistance Thermometers units, A Selector and a Heat Balancer.

ONLY DUNHAM DIFFERENTIAL HEATING USES

FLEXIBLE STEAM

A PROVEN MEDIUM FOR HEAT COMFORT

Ontario Hospitals to be Classified in Grant Revisions

HOSPITALS in Ontario are to have increased provincial grants which will be calculated on a new basis more equitable to those hospitals providing the more costly services.

In December Dr. R. P. Vivian, Minister of Health, announced the first stages of this revision. Fourteen hospitals in Toronto, Kingston and London are to have their grants raised substantially as of January 1. Other hospitals will have the benefit of revised grants later as soon as divergences in accounting practices in these hospitals can be overcome and Departmental approval given to their system of records and cost accounting.

Hospitals teaching medical students and as a result bearing additional financial burdens are to be placed in Group "A". These are: The Toronto General, Toronto Western, St. Michael's, Hospital for Sick Children, Kingston General, Hotel Dieu in Kingston, Victoria and St. Joseph's in London. Other larger hospitals in university medical teaching centres but not themselves engaged in teaching will be placed in Group "B". So far the hospitals listed in this group happen to be located in Toronto, East General, St. Joseph's, Women's College, Wellesley, Mount Sinai and Salvation Army Grace Hospital. Based on the findings of a cost study already announced, the cost of standard care in Group "A" hospitals is placed at $4.43 and in Group "B" hospitals at $4.22 per diem. The new grants are to be related to these figures. (In the interval since this study was made costs have advanced very rapidly, now being considered to average over five dollars per diem in these groups.)

In Group "C" are other public hospitals with a bed capacity of more than 65 beds and in Group "D" those with less than 65 beds.

The municipal rate of payment for indigents will remain the same to all hospitals ($2.25) and the graded increases will be entirely in the provincial grant. This will not be a specific sum but will be worked out through a formula taking into account a number of factors. It does mean this, that the former grant of less than $400,000 to the fourteen hospitals listed will now total over a million dollars annually. As an ilustration, one large hospital which received some $96,000 in 1944 will have its provincial grant increased to $285,000. One hospital in Group "A" with a limited number of public beds and with these showing a low percentage of occupancy will receive a reduced grant. This grant is in respect to all ward patients, not merely the indigent patients.

We are informed that the provincial payment, however, will still be considerably short of actual cost. If a hospital has 40 per cent beds for public patients, it would get 40 per cent of the difference between $2.25 and the adjusted 1945 group cost, but with a restrictive maximum of $1.00 for "A" hospitals, 75 cents for "B" hospitals.

It is anticipated that the increasing of grants to more nearly meet the cost of ward care will permit hospitals to avoid passing on the burden of ward losses to the paying patient. Further increases in charges to private patients is undesirable, and it is hoped that these charges ultimately can be reduced.

In discussing future developments the Minister stated that many other hospitals throughout the province need additional assistance. This will be extended as rapidly as possible, but a yardstick must be set up to deal with the disparity in costs between hospitals offering similar services. "Problems confronting convalescent and incurable hospitals are also being taken into account."

In referring to a need for a new type of hospital accommodation, Dr. Vivian said: "The important first step is to provide an increased number of beds for the chronic and incurable patients. The province in the last two years has given in grants an amount of almost $500,000 to aid in construction of this type of hospital. Consideration must be given to provision for care of the convalescent, probably within the larger general hospitals by addition of a low unit cost service . . . An extension of the principle of increased subsidy in the near future to assist convalescent and incurable hospitals will be forthcoming."

Tuberculosis Hospitals

An increase in provincial grants to sanatoria for the treatment of tuberculosis, which will amount to about $500,000 a year, has also been announced. The grants will not only be increased, but will be paid on a new principle, the basis of service rendered by each sanatorium.

"The increased grants," said Dr. Vivian, "recognize the fact that sanatoria giving special service should receive special financial consideration. They also recognize a responsibility that rests with the provincial government in providing such care for the control of tuberculosis."

Instead of the present flat rate of $2.10 per day per patient paid to sanatoria by the province, a minimum rate of $2.10 per patient per day has been set, with a maximum of $2.85. Grants will be paid on a sliding scale to each sanatorium, based upon a uniform cost accounting system and an average cost of each item that goes to make up the total cost per day.

Medical School at Ottawa

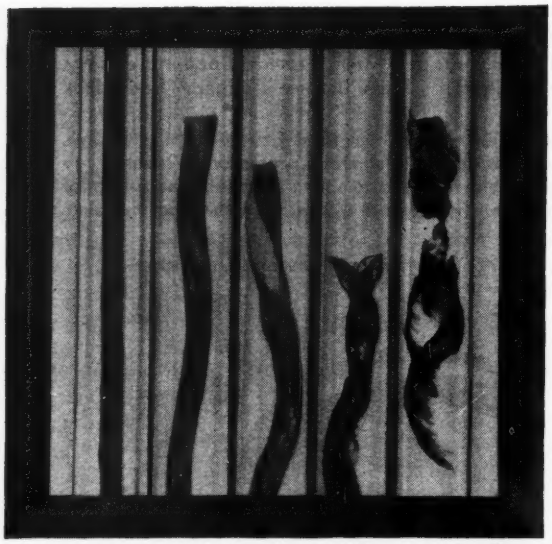
The University of Ottawa has organized a medical school to be operated as one of the faculties of the university. A first year class began its instruction in October and the second-year work will be undertaken next year. A new $400,000 medical building has been planned.

V.D. Expert Resigns

Dr. Donald Williams, medical director of the B.C. board of health's division of venereal disease control, has resigned to resume private practice.

During the war Dr. Williams, then lieutenant-colonel, was adviser on V.D. control to the armed services with headquarters at Ottawa. He did much to organize control methods and to arouse public opinion and action. A graduate of Manitoba, he was on the staff of the medical school there before going to Vancouver prior to the war.

Surprising differences revealed in catgut digestion



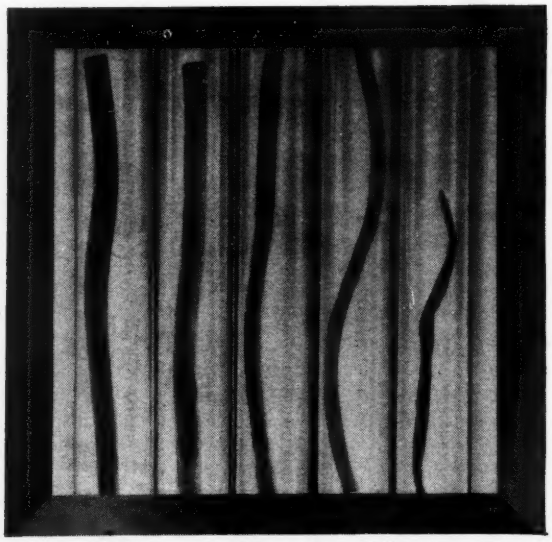
Enlarged photograph of five stages of digestion of surface-chromicized gut in trypsin solution.

Surface-Chromicized Catgut

THE MATERIAL: Surface-chromicized after spinning and drying. The chrome concentration is very high in the surface layers and relatively low in the core of the strand.

THE RESULT: In enzyme solution, the core of most surface-chromicized catgut digests readily, leaving a hollow cylinder which separates into ribbons.

This cylinder may be excessively resistant to enzyme action and persist in tissue, frequently leading to knot extrusion.



Enlarged photograph of five stages of digestion of Tru-Chromicized gut in trypsin solution.

Ethicon Tru-Chromicized Catgut

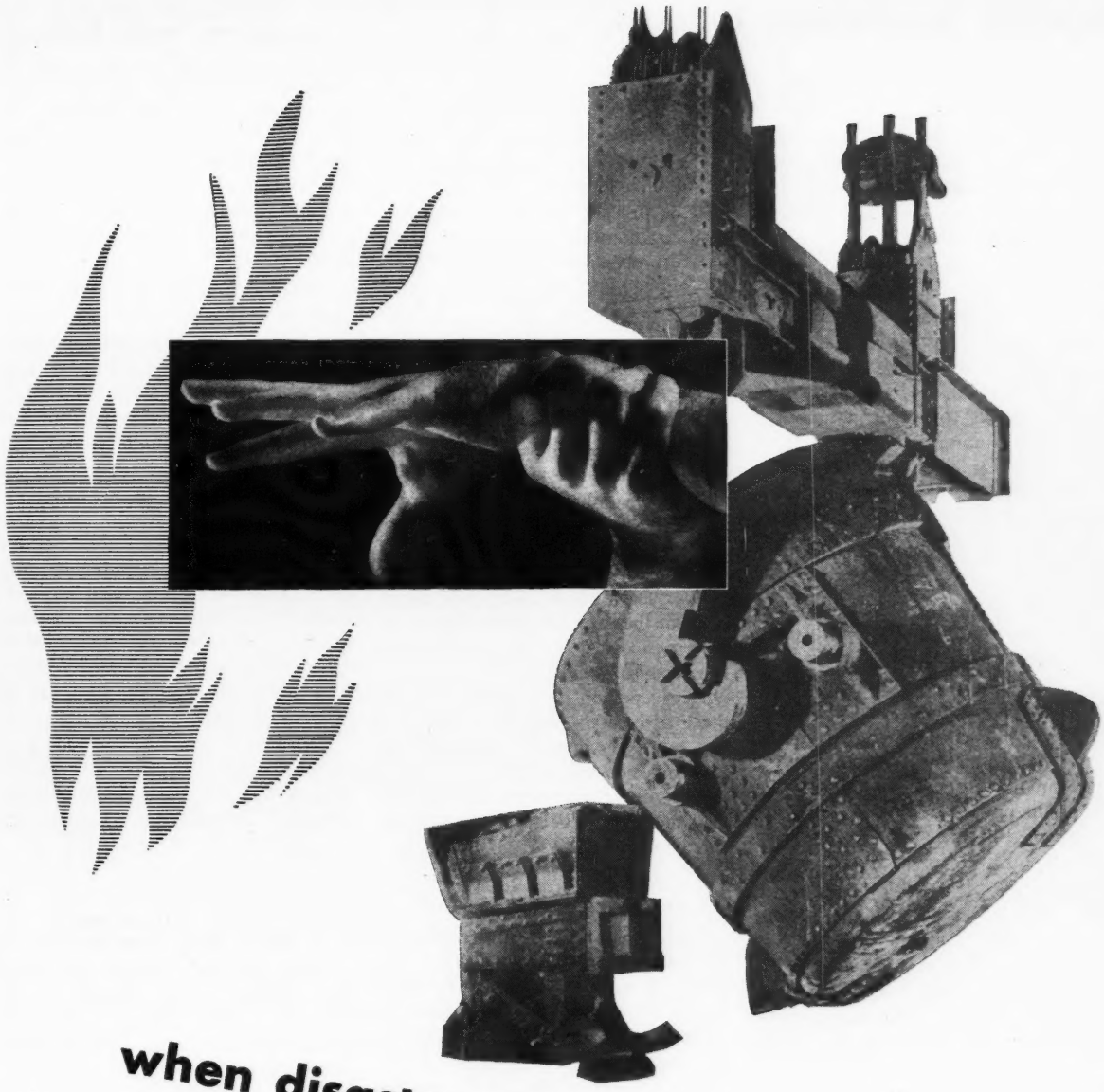
THE MATERIAL: By the Tru-Chromicizing method, individual ribbons of catgut are soaked in chrome bath before they are spun into strand, permitting uniform deposition and full control of chrome concentration.

THE RESULT: The Tru-Chromicized strand has the same chrome content from periphery to center, and hence exhibits uniform enzyme resistance throughout digestion. Ethicon's Tru-Chromicized gut digests on the surface and retains its integrity as a unified suture until digestion approaches completion. Total digestion eliminates knot extrusions.

ETHICON
Sutures

The only Tru-Chromicized Catgut

Johnson & Johnson
LIMITED MONTREAL



when disaster strikes!

In first-aid stations and medical departments of large and small industrial plants, 'Lyovac' Normal Human Plasma is the blood substitute of choice to combat disaster . . . because it is so easily and quickly prepared for administration—without typing or cross-matching!

One clinician reports: "When acute collapse occurs . . . plasma should be given rapidly. Since in these circumstances there is an acute failure of venous return to the heart, the fluid introduced must to a considerable extent supply this venous return."[1]

1. J. A. M. A., *128*:475-479, June 16, 1945.

Stable, portable, easily and quickly restored to the normal state, 'Lyovac' Normal Human Plasma is ideally suited for the treatment of victims of hemorrhage, shock, severe fractures and burns, and in conditions associated with hypoproteinemia.

• • •

'Lyovac' Normal Human Plasma, a development of Sharp & Dohme research, is supplied in bottles to yield 50 cc., 250 cc. and 500 cc. of restored plasma. Council-Accepted. Sharp & Dohme (Canada), Ltd., Toronto 5, Ont.

'LYOVAC' Normal Human Plasma SHARP & DOHME

Codeine Restrictions Relaxed

The Chief of the Narcotics Division, N. H. and W., Col. C. H. L. Sharman, has announced some relaxation in the codeine regulations as a result of considerable improvement in the supply situation. The communication reads in part:

"As of the effective date (January 1, 1946), retail druggists, under the amended Regulations, will be permitted to sell, *without prescription*, preparations containing one-eighth grain or less of Codeine per tablet or other solid form; or liquid preparations containing one-third grain or less of Codeine per fluid ounce, when combined with other medicinal ingredients, provided that the maximum dose prescribed for any such preparation contains either,

(a) one such ingredient not less than the amount prescribed by the British Pharmacopoeia as a minimum dose for such ingredients, or

(b) two such ingredients having a similar action, each not less in quantity than one-half of the amount prescribed by the British Pharmacopoeia as a minimum dose for each such ingredient respectively, or

(c) three such ingredients having a similar action, each not less in quantity than one-third the amount prescribed by the British Pharamcopeia as a minimum for each such ingredient respectively."

Physicians are reminded that the regulations respecting the sale and use of Codeine provide [3(1)] "that no retail druggist shall sell or supply straight codeine or any preparation containing any quantity of any drug on the narcotic list except

(i) upon a written order or prescription therefor signed and dated by a physician, dentist or veterinary surgeon whose signature is known to the said druggist or, if unknown, duly verified before such order or prescription is filled, or

(ii) in the case of codeine or codeine mixed with other medicinal ingredients, upon an order or prescription communicated by telephone to the druggist by a physician who states that an emergency exists in relation to a specified patient and undertakes to deliver, within thirty-six hours of the time that the order or prescription is so communicated, to the druggist an order or prescription therefor, duly signed and dated."

The regulations also require that:

"(2) No order or prescripton mentioned in subsection one of this section shall be filled upon more than one occasion, and such order or prescription shall be fiilled by such retail druggist and be available for subsequent inspection." , , , , ,

"(5) Every physician, who communicates an order or prescription for codeine to a druggist by telephone, shall within thirty-six hours confirm the same to such druggist by a written order or prescription duly signed and dated."

Every person who violates any of these provisions shall be liable to a fine not exceeding one thousand dollars and not less than two hundred dollars, or be imprisoned up to eighteen months, or to both fine and imprisonment.

Calgary Technicians Graduate

Eight graduates of the School of Medical Technology at Holy Cross Hospital, Calgary, were given their diplomas at a special graduation ceremony on December 2nd. Diplomas were presented by Dr. R. C. Riley, director of the school, and the C. S. L. T. diplomas were presented by Dr. Lola MaLatchie. The class address was given by Miss Nancy A. Hannah and the address to the gradates and their friends was delivered by the Most Reverend Francis P. Carroll, D.D., Bishop of Calgary. Musical selections were given by Dickie Moore and Berneice Dowling.

Maple Creek Fire Kills Seven

A fire which apparently started in the food-elevator shaft of the General Hospital at Maple Creek, Sask., on December 10th gutted the building and smothered seven of the 16 patients in the hospital. Loss to the hospital was estimated at $50,000.

Ages of the patients killed ranged from 61 to 84.

Indian and Eskimo Care Under Dept. National Health

The medical and hospital care of Indians and Eskimos has now been transferred from the Ministry of Mines and Resources to that of National Health and Welfare, thus consolidating the care of these wards of the government with other health activities of the Federal Government.

Order-in-Council No. P.C. 6495 reads in part as follows:

"His Excellency the Administrator in Council . . . is pleased to transfer and doth hereby transfer the control and supervision of that part of the Public Service administering the medical care and hospitalization of the Indians, including Eskimos, together with the staff now employed in the said part of the Public Service and the hospitals, equipment and other physical assets used in connection therewith from the Minister of Mines and Resources to the Minister of National Health and Welfare . . . as of and from the first day of November, 1945."

Dr. P. E. Moore is continuing as Acting Superintendent of Indian Health Services, and a programme designed to fulfil this Department's responsibilities will be worked out.

Halifax V. G. H. Pharmacist Retires After Long Service

Miss Bertha Ogilvie Archibald has applied to the Board of the Victoria General Hospital for permission to retire on superannuation after 29 years' service.

Miss Archibald had barely taken over her duties as assistant pharmacist at the hospital when the Halifax explosion of December 6, 1917, occurred. Her chief, Dr. Putner, had to assume the superintendency temporarily and she had to take over the tremendously increased duties of the hospital pharmacist. Wrapped in heavy clothing because of the intense cold due to shattered windows, she acquitted herself admirably in this sudden emergency.

Miss Archibald had much to do with designing the pharmacy in the new hospital now nearing completion.

Sickness is the vengeance of nature for the violation of her laws.—*C. Simons.*

Correspondence

Employment of School Girls

To the Editor,
Dear Sir:

From time to time we employ teen-age girls in our hospital and we are wondering if, by so doing, we are violating any regulations respecting the employment of young people. Must we get permission from their parents, or should we get permission from some board?

Miss ————, Reg.N.

Answer

In your province (Ontario) we are informed by the Chief Inspector of the Department of Labour that the *Adolescent School Attendance Act* requires that before any person between the ages of 14 and 16 can be employed, an exemption certificate must be secured from the local school attendance officer. Presumably this would apply only if teen-age girls were employed during school hours, but this could be clarified by the local school attendance officer.

As for the *Factory, Shop and Office Building Act,* it would appear that the restrictions prohibiting the employment of any person under 14 years of age (apart from the require of the *School Attendance Act)* only apply to factories, shops, bake shops, restaurants and office buildings. Therefore your only local requirement of clearance up to the age of 16 years would be with the school attendance officer.—Editor.

* * *

Employees Saving Plan

To the Editor:

There is no doubt that pension plans for employees are much to be desired but unfortunately, they are expensive. The cheapest plan that may be obtained today is the Dominion Government Annuity Plan, but one has only to study it to realize that it provides little for so much. It is not the low salaried employee that makes a pension plan financially onerous at its inception, but those employees who by virtue of their advanced and advancing years (and they are the ones most to be considered) make the initial outlay for the employer costly. The yearly contribution that this employee would have to make is not commensurate with the pension that would be earned at the age of retirement. Pension funds are vehicles for large corporations with large resources, a condition that does not obtain with our hospitals. This year one of our large hospitals set aside $60,000 for a superannuation fund but a glance at its revenue and expense account disclosed a deficit for the year of $55,000. The answer is obvious.

As an alternative, certain corporations with moderate resources have embarked upon and with success, a scheme termed *employees saving plan* whereby the employee agrees to a small monthly deduction from his salary, the employer in turn crediting the employee's account with an equivalent amount. These savings are then paid out to the employee upon retirement—with any reservation the employer may see fit to impose when an employee leaves or is dismissed before a certain length of service has been earned by the employee.

The Federal Government has just made downward income tax amendments, thus an opportune time to advance the savings plan.

The hospitals' liability would be gradual and, being discharged over a period of years, should not prove onerous. Furthermore, there would, no doubt, be employees who have reached a salary limit for the work in which they are employed; nevertheless, they are rendering efficient and reliable service and should be rewarded. In such cases, in lieu of a salary increase, the hospital could give these individuals a periodical credit to their savings account of say $50 or $100, or such other amount as circumstances warrant—an arrangement which would work to the advantage of both employer and employee.

W. R. Chenoweth, Montreal

National Appointments

Plans for appointing an architect to aid the federal government in improving hospital designs were announced by the Hon. Brooke Claxton, Minister of National Health and Welfare, last month at a dinner in Ottawa for the members of the Dominion Council of Health.

"Hospital design has become increasingly specialized," said Mr. Claxton. "We aim to get an architect of high standing to act in a consultative capacity in connection with hospitals of the Dominion Government and also be available for consultation by provincial and local authorities and their own architects. It would be his job to have the best and most up-to-date knowledge of different types of hospitals appropriate to different sizes of communities."

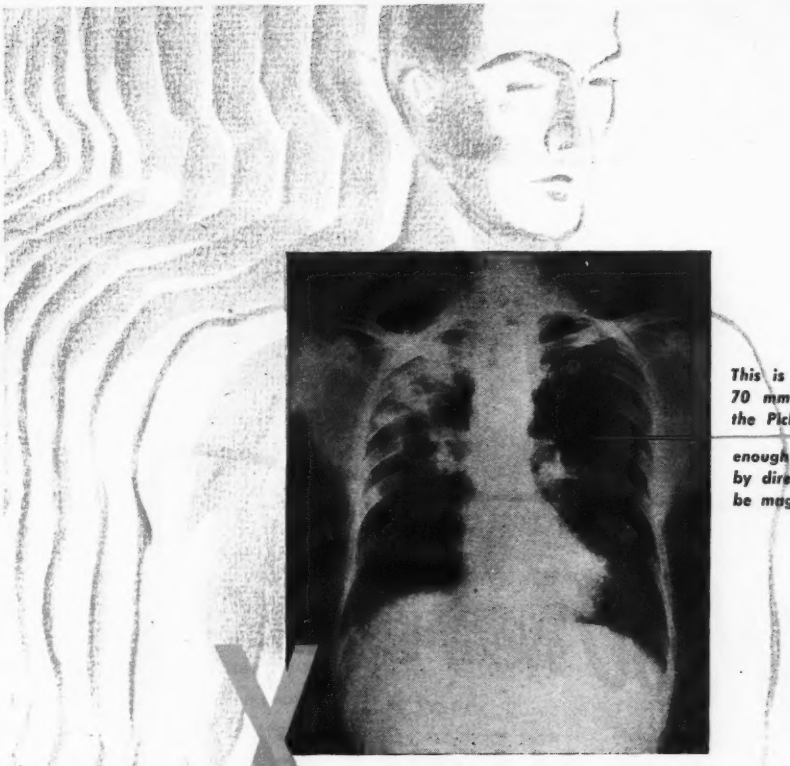
He also announced appointment of four chiefs of divisions within the department; Dr. L. V. Janes of Edmonton as chief of the dental health division; Dr. B. D. B. Layton of Toronto, venereal disease control; Dr. R. G. Ratz of Kitchener, civil service health; and Dr. C. G. Stogdill of Toronto, mental health.

Dr. Janes served in World War I and later practiced in Edmonton. Enlisting in 1939, he has been director of dental services overseas since 1942.

Dr. Layton, who succeeds Major George Leclerc as chief of the venereal disease control division, studied medicine at Toronto and in England. Joining the R.C.A.M.C. in 1942, he has been venereal disease control officer for the Canadian Army overseas since 1944.

Dr. Ratz, chief of the civil service health division, graduated from Toronto and practised medicine in Kitchener. During World War I he served in the R.N.V.R. and in World War II as officer commanding the 24th Canadian Light Field Ambulance overseas.

A native of Seaforth, Ontario, Dr. Stogdill specialized in psychology and psychiatry at the University of Toronto. Since 1931 he has been director of mental hygiene in the public health department of the city of Toronto. He recently returned from overseas duty with the medical branch of the R.C.A.F.



This is the actual size of the 70 mm. radiograph taken by the Picker MINOGRAPH. Large enough to disclose pathology by direct viewing, it may also be magnified for critical study.

X-ray for mass chest surveys

In the new *Minograph,* a revolutionary x-ray apparatus for mass chest surveys, Picker will offer equipment that is the last word in portability, economy, and efficiency. Its design is based on careful study of actual field conditions, in cooperation with the foremost authorities on the subject.

Completely portable, the *Minograph* can be set up (or dismantled) in less than 30 minutes. It permits x-raying, by a single operator, of up to 300 subjects per hour. Exposures are electronically and automatically adjusted to varying chest densities, with a positive built-in identification system. A completely new electrical system assures trouble-free service under the hard usage a portable apparatus must inevitably receive.

Your local Picker representative will be happy to explain this remarkable apparatus in detail . . . or write us for further information.

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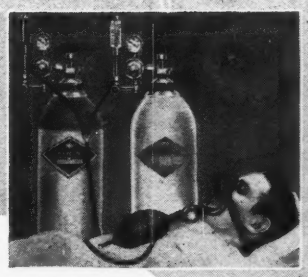
Heidbrink Model 75-B Oxygen Tent



B-L-B Inhalation Outfit, for oxygen or helium-oxygen administration.

Oropharyngeal Catheter Outfit, especially effective for post-operative treatments.

Apparatus for administering oxygen

● The trend toward making available at least one piece of oxygen administering apparatus on each floor of the modern hospital is greatly facilitated by the extensive line of equipment manufactured by The Ohio Chemical & Mfg. Co. Where a modern oxygen tent outfit is not available the Heidbrink Oropharyngeal Catheter outfit, B-L-B Inhalation apparatus, and portable Bedside Oxygen units all can be depended upon for many cases in which the use of oxygen as a therapeutic agent is indicated.

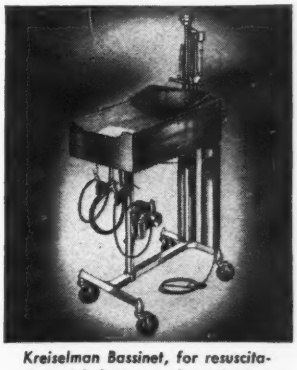
Maximum efficiency and exceptional convenience have been achieved in the Heidbrink 75-B oxygen tent outfit (illustrated above) which assures accurate and adequate oxygen supply, ample circulation and cooling, and correct limitations of both carbon dioxid and humidity. Easily handled by one person, this tent outfit can be readily collapsed to size 18 x 19 x 54 inches for convenient transportation when required for treatment in the home.

Effective treatments for asphyxia, cyanosis, pulmonary infections, etc., in infants are facilitated by Kreiselman Bassinet Resuscitators and the Hess oxygen therapy unit available for use with the Hess infant incubator. Included in the Kreiselman line are resuscitators for adults, which, when equipped with the proper masks, are also complete and adequate for the treatment of infants and children.

Ohio "oxygen therapy service," including the rental of apparatus and the supplying of therapeutic gases, is available night and day from more than 25 Ohio service branches located in principal cities. Thus oxygen therapy equipment and a dependable supply of oxygen are immediately available to thousands of physicians and hospitals.

Write for complete information on Ohio oxygen therapy equipment and oxygen rental service.

Hess Infant Incubator with oxygen therapy unit in position.



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Commonwealth Fund Sponsors Regional Hospital Experiment

IN an effort to determine the extent to which hospitals can co-operate voluntarily in a co-ordinated regional plan of health care, the Commonwealth Fund, through its Division of Rural Hospitals, is sponsoring an experiment in seven counties in western New York, these counties forming the trading area of Rochester. Stretching from Lake Ontario to the Pennsylvania border, these counties have an area of 4,715 square miles and a total population of 713,-862, including 324,975 in Rochester. Outside Rochester there are 17 hospitals, all but five (which together have only 11 per cent of the total bed capacity) being voluntary. It is proposed that these hospitals shall join with the six hospitals in Rochester in co-operation for the betterment of medical and hospital service throughout the region. Educational services would come to focus in the University of Rochester but would be shared by several hospitals in the city.

In the words of Mr. Southmayd, director of the Division of Rural Hospitals, the heart of the experiment is to determine whether a better distribution of better medical care can be achieved through "concerted voluntary action by hospitals through representative organization on a regional scale". Such improvements might come about through several channels: the extension of educational opportunities by urban hospitals, and particularly teaching hospitals, to physicians and hospital personnel throughout the region; the exchange of interns and residents; the development of consulting services in clinical medicine, laboratory medicine and hospital administration; the establishment of accepted standards of administration and operation in all the co-operating hospitals; the initiation of desirable joint services, such as purchasing; and the rational distribution of adequate hospital facilities throughout the region. To initiate and guide such developments it is proposed to establish a membership organization, in which urban and rural hospitals share on an equal footing, with a full-time executive staff.

Such an experiment in intercommunity organization has few precedents, and an important factor in the decision to begin the experiment in the Rochester region was the maturity of community organization in Rochester itself. Furthermore, the region as a whole is prosperous, well supplied with hospital beds and with physicians. The quality of hospital service both in and out of Rochester is above the average. In the opinion of the Fund, this is a situation in which the influence of regional organization can be determined — as nearly as is ever possible in the complicated field of social relationships —as a single variable.

Through the community fund Rochester will provide $10,000 initially toward the administration of this experiment. The Commonwealth Fund has indicated its willingness to provide $75,000 more for this purpose and up to a maximum of $200,000 annually for capital improvements, over a period of at least five years. A portion of the money is to be devoted to administration and educational programmes and the major portion as grants-in-aid to a number of hospitals in smaller communities for building programmes and the purchase of equipment. The educational programme will be a major function of the Regional Council to be set up and will include the organization and administration of a continuous post-graduate programme for physicians, including clinical conferences, refresher courses, residencies and fellowships.

Consideration is being given to a rotation of interns and residents among the hospitals in the region, refreshed courses for graduate nurses, operating and delivery room courses, institutes and exchange opportunities for laboratory and x-ray technicians, dietitians, medical record librarians and admitting officers, and to the development of opporunities for more affiliations in undergraduate nursing.

It is proposed to extend consultation services for x-ray, pathology and anaesthesia and for hospital administrative and departmental problems. There will be meetings and regional institutes for non-professional as well as professional hospital personnel.

The plan became operative on January first.

Labour Organizations to Stay

Organized labour is here to stay, in the opinion of Mr. O. A. Petersen, personnel manager of the B. C. Electric, who spoke at the administration course prior to the B.C.H.A. convention. The worker has a right to organize if he so desires.

Unions have done a great deal of good. Unfortunately during the organization period the type of leader thrown up was often not very admirable. That day is changing, however, and now well-trained leaders who realize the importance of co-operation are being developed.

A basic consideration to-day is that everything is so impersonal. There is no individual owner, merely a large group of unknown shareholders, and to them the individual employee is quite unknown. The artisans are not completing a unit of production any more; hence they have less interest in the finished product and think only of their wages.

An essential for good personnel relations is that the employee know more about the company (or hospital) for which he works. "Job specifications" are important but are seldom done. Every employee should know exactly what the job calls for. Moreover that should be done "right up the line"—right to the chairman of the Board.

Merit rating of each employee is worth while. Estimates of employees with potential executive or administrative ability vary from 4 to 10 per cent.

C.P.H.A. Medical Director

Dr. J. H. Baillie has been appointed medical director of the Canadian Public Health Association. In this capacity he will implement the wider post-war programme of the Association. Dr. Baillie graduated from the University of Toronto and later took post-graduate training at the School of Hygiene of that university.

AT ALL THESE BRANCHES ACROSS CANADA—Halifax, N.S. Quebec, P.Q. Montreal, P.Q. Ottawa, Ont. Peterborough, Ont. Hamilton, Ont. Windsor, Ont. Kirkland Lake, Ont. Regina, Sask. Calgary, Alta. Winnipeg, Man. Vancouver, B.C.

N. B. Doctors Present Views on Health Programme

THE New Brunswick Medical Society in a presentation in November to the Hon. F. A. McGrand, Provincial Minister of Health and Social Services, made the following points:

New Brunswick as a whole is not covered by a desirable amount of medical services.

That while the medical services available to those people residing in cities and larger towns are reasonably adequate, the same does not apply to the rural population. A typical district for medical purposes covers a radius of 20-35 miles, wherein up to seven thousand people are attended by a single doctor.

That there exists a gross shortage of medical and dental practitioners, nursing personnel, hospital accommodations of all types, laboratory facilities and trained technicians.

That there exists an inadequacy of public health services, particularly in the field of preventive medicine.

The provisions of the Heagerty Compulsory Health Insurance Bill are incapable of implementation in New Brunswick at the present time. On the other hand it should be possible for the province to receive federal assistance for health services in the order of its most urgent requirements.

The process of bringing modern, complete, medical services within the reach of all must be one of evolution.

The province should be divided into zones, which are already more or less defined by the location of existing larger hospitals. In addition sub-zone hospitals should be built in selected strategic locations and supplied with basic, diagnostic and other essential equipment. Such hospitals would take care of obstetrical practice, emergency and minor surgical procedures and provide a nucleus for carrying out Public Health services.

Transportation should be organized first so as to bring the patient to the sub-zone hospital to prevent the present excessive wastage of medical man hours due to unnecessary travelling about the community, second to move patients with major problems of diagnosis and treatment to the central large zone hospital.

Voluntary hospital insurance, such as Blue Cross, already rapidly gaining in popularity, would further encourage the establishment of these centres and help to provide for their maintenance.

Even with the fulfilment of such a rural plan there would be certain sparsely settled and poverty stricken districts which could not of themselves in any way provide for medical care. To meet the need in these areas provincially-subsidized medical services would have to be provided.

With the generally increased trend towards hospitalization the necessity for the provision of additional accommodation is apparent. The institution of convalescent hospitals would help to relieve the present congestion in already existing hospitals. Hospital provision should be made for the care of the chronically and incurably sick. The need for increased hospitalization for tuberculous and mental patients is acute and should receive immediate attention.

It is considered that the degree of medical care provided for the poor under the Poor Law as administered by the parishes is totally inadequate and in some cases non-existent. It is strongly urged that the medical care of the poor be assumed by the Province.

An improved Public Health programme is a necessary adjunct to any plan which proposes to provide increasingly efficient and desirable health services for the general public.

Attention is drawn to the second principle of the Canadian Medical Association:

"Inasmuch as the health of the people depends to a great extent upon environmental conditions under which they live and work, upon security against fear and want, upon adequate nutrition, upon educational facilities, and upon the opportunities for exercise and leisure, the improvement and extension of measures to satisfy these needs should precede or accompany any future organization of medical service. Failure to provide these measures will seriously jeopardize the success of any Health Insurance plan."

The memorandum was signed by Dr. E. W. Lunney, president; Dr. F. C. Jennings, secretary; and Dr. A. F. VanWart, chairman of the Committee on Economics.

Calgary Vote Approves Building of New Hospital

The plebescite taken in Calgary to ascertain the wishes of the citizens respecting the building of a new hospital showed an overwhelming majority in favour of the $3,000,000 project, as opposed to the counter-suggestion of a $1,500,000 project. This plebiscite was a feeler to ascertain whether or not the board could expect two-thirds of the ratepayers to support either of these projects. Before final action can be taken it will be necessary to submit a money by-law which will require a two-thirds approval.

This vote will do much to clarify the question as to whether there should be an extensive enlargement of the Calgary General Hospital on its present site across the river ($1,500,000), or whether the present buildings should be used for some other purpose and a new 600-bed general hospital be built upon another site ($3,000,000). The medical staff of the Calgary General Hospital took an active part in this campaign and, prior to the plebescite, provided a number of addresses over the radio and at various meetings.

Dr. Roxburgh Appointed

Dr. D. B. Roxburgh has been appointed medical superintendent and pathologist to St. Joseph's Hospital, Victoria, B.C. Dr. Roxburgh has been with the Army for some three and one half years and latterly was with No. 16 Canadian General Hospital. Before enlistment he was pathologist at this hospital and now returns to his old post with added administrative duties.

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J. *Obstet. Gynaec. Brit. Emp.*, Vol. 39, No. 7

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Bleach	1	10 minutes
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300 pounds white clothes.
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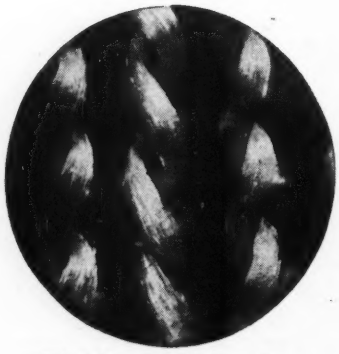
(1 lb. modified soda).
(Suds—long enough for soap to do its work).
Bleach—¾ pint of 1%.

NOTE—In break soda loosens and wets—soap cleans, lubricates and carries away soil—little bleach needed.

RESULT—WHITE CLOTHES—GOOD FEEL—VERY LOW LOSS OF TENSILE STRENGTH



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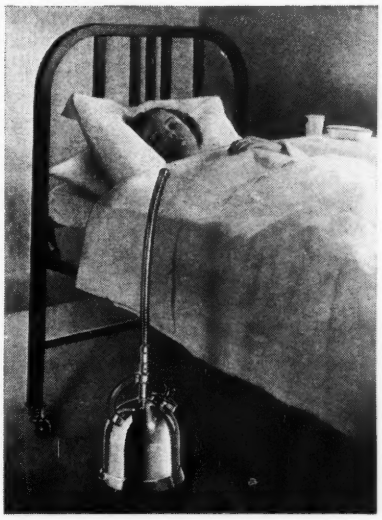

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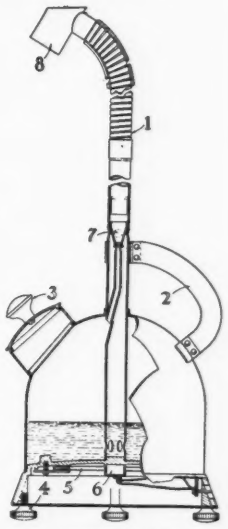

Sectional View

IMPROVED MYRICK INHALATOR complete with Flexible Inhalator Tube, Medicant Cup, Cool Bakelite Carrying Handle, and 10 feet of rubber covered attachment Cord ready to connect to electric light current. Price $51.00. Literature on Request. Approved by Canadian Engineering Standards Association
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Benjamin Warren Black, M.D.

Readers who have been keeping in touch with the work of the American Hospital Association will learn with regret of the death from pneumonia in December of Dr. Benjamin W. Black of Oakland, California, leading hospital administrator on the Pacific coast and Past-president of the American Hospital Association. Since 1928 Dr. Black has been medical director of the fine chain of Alameda County institutions and superintendent of the Alameda County Hospital. Following service in World War I, Dr. Black was State Supervisor and State Manager of the U.S. Public Health Service for Utah, 1920 to 1924. For the four following years he was Medical Director of the U. S. Veterans' Bureau at Washington, D.C. He then went to California.

A Charter Fellow of the A. C. H. A., he served also as Regent and First Vice-President of that body as well as in other capacities. In the American Hospital Association he served on various committees, was Associate Editor of Hospitals" and climaxed a long term on the Board of Trustees by becoming President in 1940. He was also President of the Western Hospital Association in 1931-32. Ben Black's clear thinking, executive ability, cheery presence and resonant voice will be sorely missed in hospital conclaves.

* * *

Mrs. Otho Ball

Mrs. Otho Ball, wife of the publisher of *Modern Hospital,* passed away somewhat suddenly early in December at their winter home in Florida. Mrs. Ball has not been in good health for some months but her death was unexpected.

* * *

H. C. P. Hazlewood, M.D.

Dr. Harry C. P. Hazlewood, senior associate of the Muskoka Hospital (for tuberculosis) at Gravenhurst, Ont., died suddenly while making his rounds on Christmas morning. Dr. Hazlewood had been on the staff of the hospital for 28 years, becoming a member of the staff on leaving the C.A.M.C. after four years of service during World War I. For many years he was assistant to Dr. W. B. Kendall, becoming Physician-in-Chief in 1939. Two years ago he relinquished this position owing to ill-health but continued as senior associate. Dr. Hazlewood was brought up in a Methodist parsonage, graduated from Toronto in 1915 and the enlisted in the C.A.M.C.

Nurses Christen Ship

Two cadet nurses of the Sage Memorial Hospital, Ganado, Arizona, had the privilege of going to Los Angeles expressly to launch a ship. This is the famous hospital where Indian nurses from all over the United States, Canada, Alaska and Mexico come for training. (See *The Canadian Hospital,* April, 1939.) The two nurses were accompanied by Dr. C. G. Salsbury, the superintendent, and Mrs. Salsbury. While in Los Angeles the Ganadoites were taken on a round of the studios at Hollywood.

He that revels in a well-chosen library has innumerable dishes, and all of admirable flavour.—*William Godwin.*

A.C.H.A. Institute

(Continued from page 42)

high per diem cost alone will suffer, and some adjustment will have to be made in its *modus operandi.* Nevertheless, Smith declared hospitals should not bother too much about costs right now, presumably because he feels with Mack[12] that there is a bright immediate future for American hospitals and does not anticipate a major "slump".

Mannix[13] painted a glowing picture of the future role of prepaid plans. It is true that statistics show the growth has been phenomenal, but the writer cannot help feeling he was a little too optimistic in his statements. In 1935 there were 10 plans in the United States with 55,000 subscribers. This year, to date, there are 85 with 16,000,000 and an average daily enrolment of 17,000.

Caution in Building

A note of warning was sounded by Dr. Morrill[14] in connection with the expansion of existing hospitals. He feels that they are overbuilding and expressed the hope that governing bodies will not think that wartime business will continue. He pointed out that Cook County Hospital, with a bed capacity of 3,400 and a 1940 patient census of 3,300, had only 2,200 patients in 1945. There are too many prejudiced observers, he went on to say, who wish to expand or build without due regard for community needs, and community needs should be the yardstick. Everett Jones expressed himself as being afraid that hospitals "are being lulled to sleep by the crazy present economic situation".

A registrant whose hospital had planned a $450,000 building programme in the spring of 1946 told the writer he was returning from the Institute with the fixed intention of dissuading his board from proceeding with their plans, not only for economic reasons, but also because the whole concept of hospital care will be changed within the next few years.

In conclusion, it would not be amiss to quote Dr. M. T. McEachern: "We must", he said, "render so good a service to the profession that they cannot help liking us", which is an excellent and praiseworthy example of what Bishop Butler has referred to as "enlightened self-interest".

Bibliography

1. Herman Smtih, M.D.: Director, Michael Reese Hospital.
2. R. C. Buerki, M.D.: Dean, Graduate School of Medicine, University of Pennsylvania.
3. K. S. Densford, Reg. N.: President, American Nursing Association.
4. Victor Johnson, M.D.; Secretary, A.M.A. Council on Medical Education of Hospitals.
5. R. C. Buerki, M.D.
6. R. F. Brown, M.D.: Medical Director, St. Luke's Hospital, Chicago.
7. Michael Reese Hospital, Chicago.
8. "The Care of the Chronically Ill in Montreal".
9. Edna Nicholson: Director of Central Service for the Chronically Ill.
10. E. A. Piszczek, M.D.: Director, Cook County Department of Health.

R. C. Buerki, M.D. (See p. 80)

A.C.H.A. Institute

(Concluded from page 78)

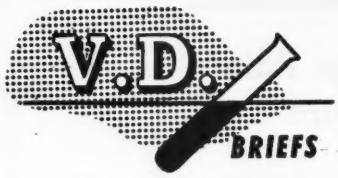
Graham L. Davis: Hospital Director, W. K. Kellogg Foundation.

C. F. Wilinsky, M.D.: Executive Director, Beth Israel Hospital, Boston.

11. Everett W. Jones: Vice-President, Modern Hospital Publishing Company.
12. J. P. Mack: Vice-President, American City Bureau.
13. John R. Mannix: Executive Director, Chicago Plan for Hospital Care.
14. Warren P. Morrill, M.D.: Director, Research, American Hospital Association.

Hospitals offering personnel advantages have less trouble obtaining and holding nurses and other personnel. Such a policy pays in the long run. —*Alma C. Haupt, R.N.*

Privacy with adequate attention is one thing; separation with neglect is another. . . . The sick are often terrified by loneliness; it is as true as ever it was that misery loves company.—*S. S. Goldwater, M.D.*



The following measures have been taken by the Canadian Armed Forces to prevent the spread of venereal diseases to the civilian population of Canada by Armed Forces personnel who are being retired or discharged from the services.

1. *Case Finding of Syphilis*

A serologic test for syphilis is done on all personnel of the Navy, Army and Air Force at the time of retirement or discharge. To ensure further follow-up, the names of all personnel with a positive or doubtful serologic test for syphilis are then submitted to the Division of Venereal Disease Control of the Health Department of the province where the former member of the forces intends to reside.

2. *Prevention of Spread of Venereal Infection*

Personnel of the Navy, Army and Air Force who are found to have venereal disease in a communicable form at the time of their medical examination prior to retirement or discharge, are retained in the Service until they have received such treatment as may be necessary to render their infection non-communicable.

3. *Re-Assessment of Every Syphilis Infection.*

All personnel of the Navy, Army and Air Force with a history of syphilis infection, contracted either prior to or during their service, are given a complete medical examination for re-assessment of their syphilis infection. A summary of their case is then submitted to the Division of V.D. Control of the Health Department of the province where such personnel intend to reside. This summary of their case can, therefore, be made available by the Provincial Health Department to any physician who may be consulted by a former member of the Armed Forces for further medical care, observation and/or follow-up of a syphilis infection for which medical care was given in the Armed Forces.

Greatest Englishman

(Concluded from page 28)

he advised the closure of the wine vats to keep out the *floating particles in the air,* and then all would be well. This was the first incident of public interest in the life of one who became renowned for other and greater works—beneficent Louis Pasteur. In his publication of this incident Pasteur stated that the floating particles from the air had produced an antagonistic fermentation in the wine.

When Lister had obtained this report and studied its possible relationship to his own problem he extended his postulates (previously mentioned) still further.

3. Suppuration comes from decomposition.

4. Decomposition comes from fermentation.

5. Fermentation comes from "the floating particles in the air".

"Follow you the Star that lights the desert pathway, yours and mine
Forward till you see the highest."
—Tennyson.

He had now seen a gleam of light as a lone star through the mists of night. The lustre of the star drew him on with an ardour amounting to a passionate zeal. It was during this period that his colleagues remarked that it was almost inconceivable how one man could accomplish all the work Lister was doing, preparing and delivering lectures at the College, demonstrating at the hospital, operating, outside lecturing and conducting his absorbing laboratory search for the answer to his problem. In his own testimony it was the gracious unfailing assistance of his wife, who undertook all his secretarial responsibilities and some of his laboratory tests, that enabled him to utilize every possible minute to the one great purpose.

In his own words Lister now deduced "The septic properties of the atmosphere having been shown to depend upon the minute organisms in it, it occurred to me that decomposition in the wound might be avoided by applying a dressing of some material capable of destroying the life of the floating particles. Upon this principle I have based a practise."

Now the fight was on, the battle called. To defeat the unknown malignant enemy meant an unknown armament to find, or to make, and to adopt into a formulated system. The investigation involved numerous experiments eventuating in the adoption of carbolic acid as the crucial agent to exterminate the living floating particles of the air. The only carbolic acid available at that time was a crude form of creosote impure and almost insoluble in water. Abstracting the impurities, the residue gave him the desired material for treating dressings, sponges, etc.

His first use of this method was on accident cases, nine in number. It is on record that all were totally free from any symptoms of infection, and all recovered satisfactorily and quickly.

Mirabile visu—wonderful to see; it had never been seen before.

(To be concluded in the February issue)

To be skilled in his craft is the first thing a man must be, if he is ever to become educated.—*Albert E. Wiggam.*

Montreal Hospital

(Concluded from page 38)

boarded over and turned into a sun deck, where patients either ambulatory or in bed can sun bathe in privacy.

When the building was taken over it was noted that additional elevators would have to be provided, as the existing ones could not carry beds or the added load which the new function of the building would create. In order to do this a central stairway was completely removed and converted to an elevator shaft capable of carrying two large-sized cab elevators. Unfortunately the footings of the building would not permit of the elevators being installed against the outside wall, thereby prohibiting the use of this space as an elevator lobby, which would have been most useful.

Decision Justified

In closing it may be restated that the choice of a building of this type for conversion to a hospital, despite the large amount of internal construction that had to be undertaken, provided it much more quickly than had the same planned building been commenced *de novo*. Such a hospital, it is estimated, would have taken, even under optimum conditions, at least two years to build. The speed with which this hospital was able to open its doors is evidenced by the fact that seven months after work had started the first wards were ready and occupied, while the complete hospital of 800 beds was finished some three months later—a total of ten months from the complete conversion. It is felt that this is a very striking example of what can be done, especially when it is understood that drawings were only started in July, 1944, two months before the actual work began.

Hospitals in Britain

(Concluded from page 50)

from this country and the Dominions". Except in Fiji and the Western Pacific territories, where the nursing service is largely staffed by the secondment of nurses from New Zealand, no regular arrangements appear to exist for the recruitment of nurses from the Dominions. On the face of it the West Indies might look to Canada in a similar kind of way. The Committee express the hope "that more nurses will in future be recruited from the Dominions for service in the Colonies". It is understood that copies of this report have been supplied through the usual official channels, but perhaps this summary of the report may reach some who are in a position to take a direct and practical interest in a matter where there is opportunity to work together for the benefit of large portions of the world's population who have not had the same opportunities.

Mrs. Eaton Goes to Vancouver

Announcement has been made of the transfer of the headquarters of Mrs. Rex Eaton to Vancouver, where she will act as vice-chairman of the Pacific Region for the Department of Labour and continue with the work she has been doing in planning the adjustment of Canada's women to peacetime employment. She will also carry on as associate director of National Employment Service.

Index of Advertisers

JANUARY, 1946

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Corbett-Cowley Operating Room Apparel is made from the finest materials obtainable. All garments are unconditionally guaranteed as to both workmanship and material. Styles Nos. 442 and 431 can be furnished with knitted cuffs which fit closely and easily into rubber gloves.

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Small, Medium, Large

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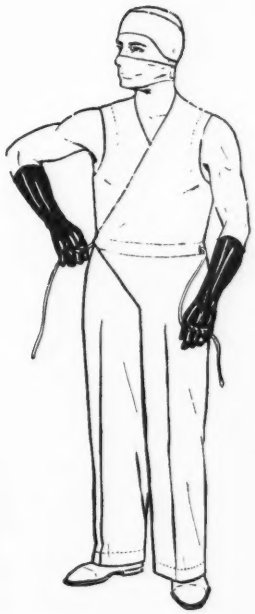
NURSE'S OPERATING GOWN



Style No. 431
SURGEON'S OPERATING GOWN

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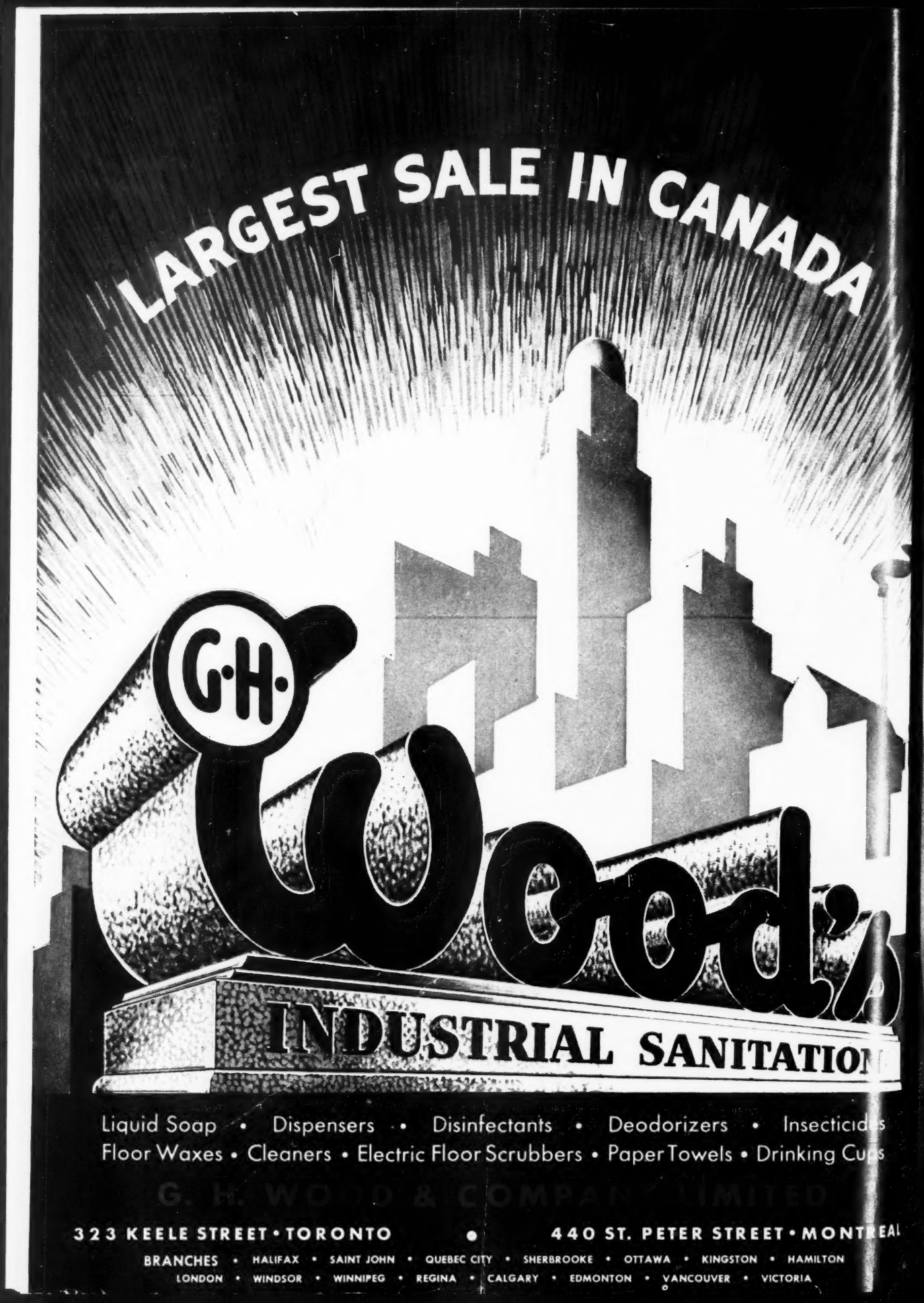
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